Audit, Finance & Risk

Thu 08 April 2021, 13:00 - 16:25

Via Microsoft Teams

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Agenda

13:00 - 13:20
20 min

1. Preliminary Matters

1.1. Apologies for Absence

Verbal *Chair*

1.2. Declarations of Interest

Verbal *Chair*

1.3. Draft Minutes of the Meeting held on 4th February 2021

Attachment *Chair*

- Item 1.3 Minutes of Meeting held 4 February 2021.pdf (11 pages)

1.4. Action Sheet

Attachment *Chair*

- Item 1.4 Action Sheet.pdf (6 pages)

1.5. Terms of Reference

Attachment *Chair*

- Item 1.5 Terms of Reference.pdf (14 pages)

13:20 - 14:10
50 min

2. Best Use of Resources

2.1. 1.20-1.40 Muskulo Skeletal Pathway Redesign Programme 2021/22

Attachment *Director of Therapies & Health Sciences, Deputy Director of Finance*

- Item 2.1a Muskulo Skeletal Pathway Redesign Programme 2021 2022.pdf (24 pages)
- Item 2.1b MSK Project Plan.pdf (1 pages)
- Item 2.1c MSK Pathways.pdf (1 pages)

2.2. 1.40-1.55 Update on the Integration of Eye Care Pathways

Attachment *Interim General Manager, Primary & Community Care Services*

- Item 2.2a Update on the Integration of Eye Care Pathways.pdf (16 pages)
- Item 2.2b Update on the Integration of Eye Care Pathways.pdf (14 pages)

2.3. 1.55-2.10 Digital Strategy Update

Attachment *Chief Digital Officer*

- Item 2.3 Digital Strategy Update.pdf (22 pages)

14:10 - 14:35
25 min

3. Governance and Assurance

3.1. 2.10-2.15 Update on Governance, Financial Control Procedures and Technical Accounting Issues

Attachment *Assistant Director of Finance (Financial Systems & Services)*

- Item 3.1a Update on Governance, Financial Control Procedures and Technical Accounting Issues.pdf (5 pages)
- Item 3.1b Appendix 1 - Single Tender Action.pdf (1 pages)

3.2. 2.15-2.20 Losses and Special Payments Report

Attachment *Assistant Director of Finance (Financial Systems & Services)*

- Item 3.2 Losses and Special Payments Report.pdf (5 pages)

3.3. 2.20-2.35 Response to Audit Wales (AW) for matters in relation to fraud, laws & regulations and related parties

Attachment *Assistant Director of Finance (Financial Systems & Services)*

- Item 3.3a Response to Audit Wales (AW) for matters in relation to fraud, laws & regulations and related parties.pdf (2 pages)
- Item 3.3b Audit enquiries to those charged with governance and management..pdf (25 pages)

14:35 - 14:55
20 min

4. Counter Fraud Update

4.1. 2.35-2.45 Annual Counter Fraud Report for 2020/21

Attachment *Head of Counter Fraud*

- Item 4.1a Annual Counter Fraud Bribery & Corruption Report 2020 2021.pdf (2 pages)
- Item 4.1b ABUHB Annual Counter Fraud Report 2020 2021.pdf (38 pages)

4.2. 2.45-2.55 Annual Counter Fraud Workplan for 2021/22

Attachment *Head of Counter Fraud*

- Item 4.2a Annual Counter Fraud Workplan - 1st April 2021 to 31st March 2022.pdf (2 pages)
- Item 4.2b ABUHB Annual Counter Fraud Workplan 2021 2022.pdf (31 pages)

14:55 - 15:15
20 min

5. Finance Update

5.1. 2.55-3.05 Month 11 Finance Update 2020/21

Attachment *Director of Finance and Performance*

- Item 5.1 Finance Flash Report M11 2020 20.21.pdf (16 pages)

5.2. 3.05-3.15 Savings Programme Update 2021/22

Attachment *Director of Finance and Performance*

- Item 5.2 Savings Programme Update 2021 2022.pdf (13 pages)

15:15 - 15:50
35 min

6. Risk and Assurance

6.1. 3.15-3.25 Audit Tracker Recommendation Report

Attachment *Interim Board Secretary*

Item 6.1 Audit Tracker Recommendation Report end of March 2021.pdf (19 pages)

6.2. 3.25-3.40 Revised Risk Management Approach and Delivery Framework

Attachment *Interim Board Secretary*

Item 6.2 Revised Risk Management Approach and Delivery Framework..pdf (8 pages)

6.3. 3.40-3.50 Freedom of Information Act Compliance

Attachment *Interim Board Secretary*

Item 6.3 Freedom of Infromation Act Monitoring Report March 2021.pdf (3 pages)

15:50 - 16:10
20 min

7. NWSSP Audit & Assurance - Internal Audit & Specialist Service Unit

7.1. 3.50-3.55 Internal Audit Plan Progress

Attachment *Head of Internal Audit*

Item 7.1 Internal Audit Assurance Progress Report April 2021.pdf (13 pages)

7.2. 3.55-4.00 Internal Audit Plan 2021/22

Attachment *Head of Internal Audit*

Item 7.2 ABUHB Internal Audit Plan 2021-22 .pdf (38 pages)

7.3. 4.00-4.10 Infection Prevention Control Final Internal Audit Report 2020/21

Attachment *Director of Nursing*

Item 7.3 ABUHB 2020-21 Infection Control Final Report.pdf (22 pages)

16:10 - 16:20
10 min

8. External Audit

8.1. 4.10-4.15 Audit Committee Update

Attachment *Audit Wales*

Item 8.1 Finance Audit Risk Committee update April_2021.pdf (10 pages)

8.2. 4.15-4.20 2021 Audit Plan

Attachment *Audit Wales*

Item 8.2 Audit Plan 2021.pdf (18 pages)

8.3.

16:20 - 16:20
0 min

9. Date of Next Meetings

9.1. 18 May 2021 – Draft Accounts

9.2. 8 June 2021 – Final Accounts

16:20 - 16:25
5 min

10. Supplementary Papers

10.1. GUH: Equipment Procurement Assurance

Attachment *Head of Internal Audit*

- Item 10.1 ABUHB GUH Equipping 2021 Final Report.pdf (36 pages)

10.2. Follow-up of High Priority Recommendations

Attachment *Head of Internal Audit*

- Item 10.2 ABUHB 2020-21 Follow-up of High Priority Recommendations .pdf (19 pages)

10.3. High Voltage Infrastructure

Attachment *Head of Internal Audit*

- Item 10.3a ABUHB High Voltage 2020-21 Final Report.pdf (23 pages)
- Item 10.3b ABHB PAQ 2021 High Voltage.pdf (1 pages)

10.4. Major Capital Project: Hospital Sterilisation and Disinfection Unit (HSDU)

Attachment *Head of Internal Audit*

- Item 10.4a ABUHB_202021 HSDU Final Report.pdf (23 pages)
- Item 10.4b ABUHB HSDU 202021 PAQ.pdf (2 pages)

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Minutes of the Audit Committee held on Thursday 4th February at 1.00pm via Teams

Present:

Shelley Bosson	-	Independent Member (Chair)
Cllr Richard Clark	-	Independent Member (Local Authority)
Emrys Elias	-	Vice Chair

In Attendance:

Judith Paget	-	Chief Executive
Ann Lloyd	-	Chair
Glyn Jones	-	Director of Finance and Performance
James Quance	-	Head of Internal Audit
Mark Ross	-	Assistant Director of Finance
Gabrielle Smith	-	Audit Wales
Chris Koehli	-	Special Advisor (Finance)
Katija Dew	-	Independent Member (Third Sector)
Stephen Chaney	-	Deputy Head of Internal Audit
Richard Howells	-	Interim Board Secretary
Martyn Edwards	-	Head of Counter Fraud (Finance)
James Calvert	-	Medical Director
Danielle O'Leary	-	Head of Corporate Services, Risk & Assurance
Linda Alexander	-	Assistant Director of Nursing
Helen Sweetland	-	Independent Member (University)
Tracey Veale	-	Audit Wales
Emma Guscott	-	Committee Secretariat

Apologies: N/A

AC 0402/01 Welcome and Introductions and Apologies for Absence

The Chair welcomed everyone to the meeting.

No apologies for absence were noted.

AC 0402/02 Declarations of Interest

There were no Declarations of Interest to record.

AC 0402/03 **Minutes of the Meeting held on 3rd December 2020**

The minutes of the meeting held on 3rd December 2020 were agreed as accurate, subject to the following amendments of minutes highlighted from 22nd October 2020:

AC 2210/11: Internal Audit Governance Review for COVID-19 Pandemic and Action Plan:
The only outstanding recommendation related to the availability of malware/software for people using their own devices at home. It was noted that a further update had been requested from ICT however, it was understood that most permanent employees would *not* be using their own equipment. **Action: Secretariat.**

The Chair confirmed that progress on specific service efficiencies would be included as a standing item on the agenda for future meetings. **Action: Secretariat.**

AC 0402/04 **Action Log:**
AC 0312/06:
***Disaster Recovery Plans*:** The Board Secretary provided an update on the previous logged Action and had liaised with the Head of ICT services. This would be discussed as part of the Audit Tracker item.

***Individual and Team Job Plans*:** The Medical Director provided an update on the current position.

It was acknowledged that the current position was unacceptable as the Health Board was not where it needed to be and the Medical Director welcomed the opportunity to undertake further reviewing of the job planning processes.

The Medical Director highlighted that;

- Due to the current pandemic position, the Health Board suspended Supporting Professional Activity (SPA) plans as all job plans had been subject to change.
- The Job Plan should be an accurate reflection of the work being undertaken in order to provide assurance that organisational objectives were being met.
- The Job Plan should be the main tool for managing the medical workforce.

- The Medical Director planned to meet with colleagues next week to reframe discussions with consultants regarding job planning and how the new healthcare system should work to ensure the system was optimised.
- At the time of discussion, there was no standardised SPA time across all specialties. This was being reviewed alongside medical workforce colleagues.

The Vice Chair queried if the future job planning for medical colleagues would be different. The Medical Director confirmed that the Wales NHS Medical Directors were collaborating and considered Team Job Planning as the most appropriate way to ensure fairness and transparency for all doctors.

The Special advisor for Finance asked how job planning could be utilised to deliver the new models of care. The Medical Director stated that he had discussions with the Chief Executive about a potential review of the divisional structures and it was noted that this was an opportunity to create models of care that transcend the parameters of Primary and Secondary care.

The Chair requested a further update from the Medical Director on progress to be provided to the July Audit Committee. **Action: Medical Director/secretariat.**

AC 0402/05 **Counter Fraud Update:**

The Head of Counter Fraud provided an update to the committee. The report referred to the National Fraud Initiative (NFI). The Committee was advised that approximately 5000 data matches had been returned from the NFI and work would commence on scrutinising the data immediately.

The Committee was advised that some delays had occurred in relation to the taping of interview under caution because of COVID restrictions. However, assurance was provided that anyone with criminal liability would be held accountable.

Independent Member from the Third Sector raised a query in relation to investigation delays due to COVID, if there were potential financial implications and how these were monitored. The Head of Counter Fraud reported that in

cases where fraud was identified, interim action was taken to ensure any financial payments ceased whilst investigations were ongoing.

The Special Advisor for Finance asked about the position on completing criminal investigations before completion of internal disciplinary investigations and the potential implications of this. The Head of Counter Fraud stated that a protocol was in place with operational workforce and under normal circumstances Counter Fraud would conduct an interview as part of the criminal process and to inform the disciplinary process.

The Special Advisor for finance asked the following questions:

1. Was there a way that the Health Board could expedite the amount of time and resources used by the finance team when dealing with the NFI?
2. Are the current working arrangements reducing the volume of referrals to the Counter Fraud Team and how was the Health Board publishing cases to raise awareness?
3. In relation to the Clue-3 software, are there any implications for Data Protection around sharing information with other agencies?

The Head of Counter Fraud provided clarity on the points;

1. The Cabinet Office had high expectations with regard to delivery and high percentage of data matches had already been identified and dealt with by the Health Board.
2. The Committee was informed that when cases were presented at court, the interest of local and National press created the potential to defer criminal activity. The number of referrals had not decreased and the Health Board would seek to exploit all media to further raise awareness.
3. Working protocols are in place aligned with other agencies, to avoid information governance concerns. Clue-3 is a secure and well tested investigation management system that has been used by the Police for over 20 years and information will only be shared upon approval. It was highlighted that the Data Protection Act (section 33) facilitated the disclosure of information for these purposes.

The Vice Chair commented that in relation to points of learning for the Health Board, was there a management development need to share learning on themed issues, e.g working elsewhere when on leave/sick. The Head of Counter Fraud confirmed that the Health Board had well established measures in place to prevent this conduct.

Audit Wales queried the measures put in place by the Health Board to avoid duplicate payments. The Head of Counter Fraud confirmed that procurement ran monthly checks to identify any anomalies. Audit Wales asked for clarification on the NFI data extract timeframe and whether or not this impacted the number of matches coming into the system. The Head of Counter Fraud confirmed that the data extract captured each transaction rather than taking a data sample. Audit Wales agreed that the concerns would be shared with Audit Wales colleagues assigned to the NFI. **Action: Audit Wales**

AC 0402/06 **Efficiencies:**

The Director of Finance and Performance (DOF) introduced the report. The committee noted and acknowledged the report on the MSK (Musculoskeletal Transformation Programme) and noted that a full presentation would be provided at the next meeting. The DOF reported that resource had been provided to clinically assess the need for consultant follow-up review of post-operative patients (orthopedic shoulder procedures) using a PROM. The Special Advisor for Finance asked that when this was discussed at the next meeting clear timescales for implementation should be provided; the presentation should be clear about how this programme of work will feed into the annual plan; Identify the improved outcome for patients and how the new models of service would provide better use of resources. **Action: Director of Therapies, Health and Sciences/Secretariat**

It was noted by the Chair that this was one area of the efficiency programme and that the DOF would work with the secretariat on a work programme over the next year setting out when each area would be discussed by the committee. **Action: Director of Finance/secretariat.**

AC 0402/07 **Finance Report**

The Committee noted the report and the DOF and Performance highlighted the outstanding issues with Capital funding had been agreed with WG. The Committee noted provisions being made for untaken annual leave due to the pandemic and the opening of GUH. It was confirmed discussions had taken place with Welsh Government to finalise funding to accommodate this.

The Committee was advised of the draft budget letter from Welsh Government which provided a 2% uplift from 2020/21 which would provide for minimal growth. The committee noted that WG would be withholding funding of £20 million for NHS Wales Mental Health Services and additional funding of £25 million for the Digital Programme. The Committee was advised that in the next year the financial plans will be developed as part of an integrated planning approach- service, workforce and financial plans to produce the Annual plan. To support this approach and the need to simplify the planning approach, the financial plans will consider three broad areas:

- Core plans
- COVID- related
- COVID recovery
-

The DOF highlighted the proposed resource allocation principles and confirmed an enhanced focus on areas where the Health Board could save and disinvest in some areas whilst ensuring appropriate services were maintained.

The Special Advisor for Finance queried, in relation to resource allocation and the disinvestment section of the report, the level of confidence the Health Board had in its ability to deliver these objectives in 2021/22. The Director of Finance confirmed that this would require acceleration on work on some of the pathways and a National approach to identify potential areas that could be further optimised. Acceleration in this area would provide further clarity on how the Health Board could invest in other areas. The committee requested firm plans to be developed with details on the savings programme for 2021/22 with quarterly milestones put in place to be provided to the committee. **Action: Director of Finance and Performance.**

The Chair highlighted that there will be a Board session on funding allocation at the end of February 2021 with the draft annual plan outlining potential areas of disinvestment.

The Vice Chair queried, in relation to the three themes of baseline services if the modernisation agenda would form part of the Covid recovery plan. The Director of Finance and Performance confirmed that it would be a consideration and that this was unique opportunity to approach baseline services, in an innovative way.

AC 0402/08 Schedule of Decisions

The Committee noted the schedule of financial decisions from 1st October 2020 to 18th December 2020. The Director of Finance reported to the Committee that the Strategic and Tactical meetings had been stood down from 18th December 2020 and the usual Executive Team process had resumed.

The Special advisor for finance queried, in relation to the tactical financial decisions, why the Seegene machine totaling £1.3 million was a Chairs Action. The Director of Finance clarified that this was a one off investment needed for the Pathology testing centre in order to provide effective services due to the pandemic and would have been discussed in Strategic group meetings. The committee asked for confirmation that the Chairs Action had been reported to Board, if not this could be picked up at the next Board meeting. **Action: Board Secretary**

The Special Advisor for Finance raised the following points in relation to the strategic section;

1. Transport links to GUH and the use of minibuses: was this a short term issue due to the pandemic or a long term requirement?
2. What was the Health Boards long term strategy for the use of St Josephs?
3. What are the plans going forward for the use of off contract agency staff?

The Director of Finance confirmed the following;

1. The transport to GUH was agreed as a temporary service provided on a fixed term basis to be reviewed after that term. Some of the transport provision had already began to be stepped down due to low usage due to the need not being as great as initially anticipated (based on staff feedback).
2. There was a contract in place with St Josephs for the last 10 weeks of the financial year, to provide outpatient theatre and diagnostic care based on reduced usage. As part of the recovery plan the Health Board had raised the issue with Welsh Government on the use of the

independent sector and were looking at whether or not St Josephs could continue to be used however, there were no firm plans at present.

3. This was a short term plan to ensure the Health Board had a sufficient workforce in place towards the end of this year. The long term plan, on the basis that COVID subsided, was to ensure that the bed status met the agreed level in the original Clinical Futures plan. If this was achieved it would reduce the need for agency staff.

The Chair queried the payment agreed by the Strategic group of £10,800 for the use of the Caldicott Choir Hall by Covid mass vaccination programme and whether or not this was in operational use. It was agreed that the status of this decision would be clarified. **Action: Director of Finance and Performance.**

AC 0402/09 Risk and Assurance

Audit Tracker

The Committee noted the Tracker and was advised that the COVID Pandemic response had minimised action on this subsequently, 7 aspects of the Audit Tracker remain in Amber.

In relation to recommendation *100 (IA) updating the ICT disaster recovery plans*; the Chair requested clarity on whether or not the updates that had been received were in relation to the original recommendations. **Action: Board Secretary and Audit Wales.**

AC 0402/10 Risk and Board Assurance Framework

The Board Secretary provided an update to the Committee and it was confirmed that three risk management sessions had been planned with the Executive Team to review the risk approach and the Risk Register. It was anticipated that the assurances for the Board would be agreed following these discussions. Audit Wales queried, whether the COVID Risk register would be incorporated into the Corporate Risk register. The Board secretary confirmed that this would be discussed during the Executive Team sessions.

The Chair sought assurance that the updated Corporate Risk Register and the Board Assurance Framework would be ready to be presented at the March 2021 Board meeting. **Action: Board Secretary and Head of Corporate Services, Risk and Assurance.**

AC 0402/11 NWSSP Audit and Assurance; Internal Audit Report

The Head of Internal Audit provided an update to the Committee and confirmed that the 'Plan to Complete' in the appendix was taken from the December 2020 Audit Committee meeting. It was noted that due to the difficulties faced by the Health Board over the last few months that the report highlighted a number of audits which were still in development.

The Chair queried which of the reports would take priority to enable the NHS Wales Shared Service Partnership to form an opinion. The Head of Internal Audit stated that it would be imperative to progress and complete all the reports as part of the pared back plan agreed with the Chief Executive. The Infection Control report, a revisit of the COVID governance arrangements and completion of the high priority follow up report would be equally important for assurance.

The Special Advisor for Finance queried whether or not there was a way the Executive Team could help prioritise these reports. The Director of Finance confirmed that the Executive Team had received and agreed on the revised Internal Audit plan and that he would liaise with the Head of Internal Audit to flag any challenges to completion with colleagues.

AC 0402/12 External Audit: Audit Wales

Audit Wales provided an update to the Committee and it was highlighted that with regard to some of the local reports some slippage had occurred while the timetable for other audits has been extended to enable input from operational staff currently responding to the pandemic. Audit Wales confirmed that revised timetables have been agreed with executive leads and that the Executive Team remains supportive of audit work at this time.

Audit Wales brought to the Committee's attention the recently published report *'Doing It Differently, Doing It Right'*, which summarised arrangements across Wales' during the pandemic and encouraged members to read this publication. It was also highlighted that a second report will be published in the coming months. Tracey Veale of Audit Wales highlighted the Annual Audit Report and raised two issues; the Clinicians Pension Tax Liability still remained an issue for 2021 and that any expenditure in relation to this

would be flagged as a significant risk in the Audit plan going forward. The Committee was advised that work was ongoing to mitigate these concerns and an update would be provided in due course.

AC 0402/13 Governance and Assurance

The Assistant Director of Finance highlighted two financial procedures for approval; both had been to the Executive team and were being discussed here in line with standing financial instructions:

- a routine update on approving orders greater than £100,000, and; the other for
- Committee approval to 'Write Off' £24,000 of bad debt.

The Committee was advised that the Assistant Director of Finance had undertaken a review of how other Health Boards in Wales were operating. A proposal had gone to the Executive team with regard to the limit of £10.00 being quite low, in order to streamline and give some delegation of write offs authority to the Director of Finance. It was confirmed all 'Write Off's' would still be reported to the Audit Committee, but only those over £25,000 would come to the Audit Committee for approval and over £50,000 to the Welsh Government.

The key dates for annual accounts meetings were agreed as follows:

- Draft Accounts Submission to Welsh Government 30th April 2021
- Draft Accounts & Report to Audit Committee Members 11th May 2021
- Audit Committee meeting to Consider Draft Accounts 18th May 2021
- Final Accounts & Report to Audit Committee Members 3rd June 2021
- Audit Committee meeting to Consider Final Accounts 8th June 2021
- Board meeting to approve Final Accounts 9th June 2021
- Final Accounts Deadline for Submission 11th June 2021

The Special Advisor for finance queried the following;

1. Would the Health Board requirement increase for Write Offs as a consequence of increasing the limit to £25,000?
2. Do debt collection agencies charge the Health Board whether they recovered debt or not?

3. In relation to the Write Offs in the report that relate to payroll. What are we doing to address overpayments and then loosing contact with the people?

The Assistant Director of Finance confirmed;

1. The Health Board would seek to bring these quarterly instead of the current procedure of once a year.
2. The Health Board was currently out to tender for debt collection agencies and that there was a fixed element for fees.
3. When errors were identified, the Health Board had processes and controls in place to ensure they did not re-occur. Development work was undertaken with Workforce to address the issue of timely completion of termination forms.

   Further work was being undertaken by workforce colleagues to streamline the Health Board ESR system to eliminate administrative errors for terminations in particular.

   The Committee approved the amendments to the accounts receivable and the approval of orders financial procedures, approved the Write Off of £24,100 and noted the other items that were within the report.

AC 0402/14 **Date and Time of Next Meeting:**
Thursday 8th April at 1:00pm via Microsoft Teams

DRAFT

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Audit, Finance & Risk Committee
8th April 2021
Action Sheet

(The Action Sheet also includes actions agreed at previous meetings of the Audit Committee and are awaiting completion or are timetabled for future consideration for the Committee. These are shaded in the first section. When signed off by the Audit Committee these actions will be taken off the rolling action sheet.)

Please note, any actions not yet complete due to staff diverting attention to COVID-19 pandemic will be rolled forward to the next Action Sheet.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
AC 0402/03	**Minutes:** **Points of Accuracy (AC2210/11):** Clarification was sought on the minute from the previous meeting. It was agreed that the Chair would speak to the Secretariat after the meeting to develop a form of words to accurately reflect the discussion.	**Chair/ Secretariat**	**April**	AC 2210/11: ***The only outstanding recommendation related to the availability of malware/software for people using their own devices at home.*** It was noted that a review of this had been requested from IT and would be followed up however it was understood that most permanent employees would not be using their own equipment.
	Reference to 'Efficiencies' page 5: Efficiencies to become a standing agenda and forward invites to executive leads to ensure attendance.	**Secretariat**	**April**	Added to April Audit Committee agenda.
AC 0402/04	**Update on Integrated Eye care Pathway:** Programme plan including, patient outcomes and financial benefits, to be presented to the next Committee, in April 2021.	**Mel Laidler**	**March**	An update will be presented at the April meeting.
	A further update from the Medical Director on progress made in relation to Job Planning to be provided to the July 2021 Audit Committee.	**Medical Director/ Secretariat**	**July**	Added to the forward work programme for August (the Audit Committee do not meet in July).

AC 0402/05	**Counter Fraud Update:** The Committee raised some concerns in relation to the number of trade creditor matches outlined within the NFI report. It was confirmed that the software used captured each transaction rather than a sample of a number of transactions. It was agreed that Audit Wales would share these concerns with Audit Wales colleagues who worked alongside NFI.	**Audit Wales**	**April**	Audit Wales raised the Committee's concerns about the trade creditor matches with Audit Wales' NFI lead. Audit Wales understands Shared Service Partnership will write to all Directors of Finance in relation to the trade creditor data matches. ABUHB to confirm if/when letter received.

AC 0402/06	**Efficiencies:** The Committee noted and acknowledged the report on the MSK programme. It was agreed that for the purposes of the future work programme, a clear work plan and updated timescales for implementation, how this would feed in to the Health Board annual plan for 2021/22, financial efficiencies (including timescales for delivery) and clarity on the intended improved outcomes for patients.	**Director of Therapies & Health Sciences /Secretariat**	**April**	An update on MSK (Peter Carr/Rob Holcombe) will be presented at the April meeting.
	It was noted by the Chair that this was one area of the efficiency programme and that the DOF would work with the secretariat on a work programme over the next year setting out when each area would be discussed by the committee	**Director of Finance/ Secretariat**	**Ongoing**	An update on the following areas will be presented at the April meeting: Eye Care (Mel Laidler) Digital Strategy Update (Mike Ogonovsky) An update on the following areas of work is scheduled for the August meeting: Agile Working (Geraint Evans) Outpatients (Julie Poole & Caroline Mills) Estates – to be confirmed Hospital Network (GUH/e-LGH) – to be confirmed
AC 0402/07	**Finance Report:** The Committee asked for further details on the savings programme for 2021/22 financial year, including a quarterly delivery profile.	**Director of Finance and Performance**	**April**	An update will be presented at the April meeting.

	Schedule of Decisions: The Committee queried the Chair's Action for the Seegene machine which totalled £1.3million as it had not been included on the previous Chair's Action report. It was agreed that this would be clarified.	**Board Secretary**	**April**	Confirmed that this was provided to the March Board. Although the contract was for a total of £1.3million the actual spend was £640k.
	Payment query: The Chair queried the payment agreed by the Strategic Group for £10,800 for use of the Caldicott Choir Hall, by the Covid Vaccination Programme, and whether or not it had become operational. It was agreed that the status of this decision would be clarified.	**Director of Finance & Performance**	**April**	The Mass Vaccination Programme Board has confirmed that Caldicott Choir Hall will not be used.
AC 0402/08	**Audit Tracker Report:** Further development and review of the tracker was required to ensure that the updates captured on the audit tracker related to the original audit recommendation. It was further agreed that specific clarity on the original recommendations for IA100 would be established and actions updated in readiness for the April Audit Committee meeting.	**Board Secretary/ Audit Wales**	**April**	Completed. The work being undertaken by Informatics around the Network and Information Systems (NIS) Directive provides assurances about the security controls and plans for improving controls. These supersede the audit tracker requirements and it is recommended that this can be marked as complete and removed from the Tracker.

AC 0402/09	**Update on Risk Register and Board Assurance Framework:** The Chair sort assurance that the updated Corporate Risk Register and Board Assurance Framework would be ready to be presented to the March 2021 Board.	**Board Secretary/ Head of Corporate Services, Risk and Assurance**	**April**	An update will be presented at the April meeting.
AC 0402/10	**Internal Audit Update:** Members noted the current position with regard to the pandemic, however, it was agreed that it would be imperative for the Health Board to complete the audit plan which had already been endorsed by the Executive Team. If any challenges in relation to completion of the agreed audits were identified, these would be raised directly with the Director of Finance & Performance who would escalate it with the Executive Team.	**Head of Internal Audit/Director of Finance and Performance**	**April**	Agreed
AC 0402/12	**Governance and Assurance Update:** The Chair highlighted that this item should appear earlier on in the meeting in future.	**Secretariat**	**April**	Item brought forward on the agenda for the April meeting.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit, Finance & Risk Committee Thursday, 8th April 2021 Agenda Item:1.5

Aneurin Bevan University Health Board

Audit, Finance and Risk Committee
Terms of Reference

Executive Summary

The Aneurin Bevan University Health Board's standing orders provide that "*The Board may and, where directed by the Welsh Government, must appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

In line with standing orders and the Health Board's Scheme of Delegation, the Board has nominated a committee to be known as the Audit, Finance and Risk Committee. This Committee has been established following the review of the governance structures for the Health Board.

The following Terms of Reference were agreed as draft at the Board meeting of 24th March 2021 and are intended to be refined during the year.

The Audit, Finance and Risk Committee is asked to approve the Terms of Reference on the basis to establish the Committee for the year and that they will be refined and reviewed during the year.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	✓
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	
Executive Sponsor:	
Report Author: Richard Howells, Interim Board Secretary	
Report Received consideration and supported by :	
Executive Team	
Date of the Report: 8th April 2021	
Supplementary Papers Attached:	

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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1. Introduction

The Aneurin Bevan University Health Board's standing orders provide that "*The Board may and, where directed by the Welsh Government, must appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

In line with standing orders and the Health Board's Scheme of Delegation, the Board shall nominate annually a committee to be known as the Audit, Finance and Risk Committee.

The Committee is formed of Independent Members of the Health Board and has no executive powers, other than those specifically delegated to it by the Board as outlined in these Terms of Reference.

The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out in this document.

2. Purpose of the Committee

The purpose of the Audit, Finance and Risk Committee ("the Committee") is to:

Advise and ***assure*** the Board and the Accountable Officer by critically reviewing the Health Board's clinical and non-clinical governance and assurance arrangements, including financial controls, the risk management system and its performance management system. It will support the Health Board in discharging its accountabilities and responsibilities for the achievement of the Health Board's objectives and organisational requirements in accordance with the standards of good governance determined for the NHS in Wales.

It will support the Health Board in discharging its accountabilities and responsibilities for the achievement of the Health Board's objectives and organisational requirements in accordance with the standards of good governance determined for the NHS in Wales.

Where appropriate, the Committee will advise the Board and the Accountable Officer (Chief Executive) on where and how its system of governance and assurance may be strengthened and further developed.

3. Delegated Powers and Authority

3.1 Governance & Assurance

The Committee will oversee the development of an appropriate Board Assurance Framework, providing an overall governance view and will comment specifically upon:

- the comprehensiveness of assurances in meeting the Board and the Accountable Officer's assurance needs across the whole of the Health Board's activities, both clinical and non-clinical
- the adequacy of the Health Board's strategic governance and assurance arrangements;
- the reliability and integrity of these assurances

and

- the processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical).

The Committee will support the development of public disclosure statements that flow from the assurance processes, including the Accountability Report, the Annual Governance Statement and the Annual Quality Statement (in association with other Committees of the Board, particularly the Quality and Patient Safety Committee, which takes a lead role for the Annual Quality Statement).

The Committee will recommend to the Board the adoption of a Code of Business Conduct for Staff and Board Members and also receiving an annual report on declarations of interest and gifts and hospitality registers.

3.2 Authority

The Committee is authorised by the Board to investigate or to have investigated any activity (clinical and non-clinical) within its Terms of Reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Health Board relevant to the Committee's remit (ensuring patient, service user, client and staff confidentiality, as appropriate). It may seek relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee);

and

- any other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outside representatives with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

As part of its primary role in advising the Board on the overall design and performance of the system of governance and assurance the Committee will seek assurance from other Committees of the Board, as appropriate, about the adequacy of the ways in which that Committee discharges its responsibilities as part of the overall system of governance and assurance.

The Committee may act on any particular matter or issue upon which the Board or the Accountable Officer may seek advice.

3.3 Sub-Committees

The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to perform specific aspects of Committee business.

4. Function and Work Programme

4.1 Governance and Assurance

The Committee's work will provide assessment and assurance of the Health Board's:

- ability to achieve its objectives and the provision of high quality, safe healthcare for its citizens. (Links to Quality and Patient Safety Committee);
- compliance with relevant regulatory requirements, standards, quality and service delivery requirements and other directions and requirements set by the Welsh Government and others;
- efficiency, effectiveness and economic use of resources and the extent to which the safeguards and protects all assets, including its people (in association with the other relevant Committees)
- compliance with Standing Orders, Standing Financial Instructions (including associated framework documents, as appropriate), Scheme of Delegation and receipt of regular reports with regard to use of Single Tender Actions;
- accounting policies, accounts, and annual report, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and management letter of representation to the external auditors;

- Schedule of Losses and Compensation and any recommendation with regard to the writing off of any losses;
- planned activity and results of internal audit, external audit (Audit Wales), clinical audit, Local Counter Fraud Specialist (including strategies, annual work plans and annual reports) and the programme of Post Payment Verification;
- adequacy of executive and management responses to issues identified by audit, inspection and other assurance activity and to monitor outcomes;
- compliance with the statutory reporting requirements of the Freedom of Information Act (2000);
- reliability, integrity, safety and security of the information collected and used (in association with the other relevant Committees);
- proposals for accessing Internal Audit services via Shared Service arrangements (where appropriate);
- anti-fraud policies, whistle-blowing processes and arrangements for special investigations;

In performing this work the Committee will review:

- All risk and control related disclosure statements, in particular, the Accountability Report, the Annual Governance Statement and the Annual Quality Statement.

  The Annual Quality Statement will be completed in association with the Quality and Patient Safety Committee which takes a lead role for the AQS and with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements;

and

- The policies and procedures for all work related to fraud and corruption as set out in National Assembly for Wales Directions and as required by the Counter Fraud and Security Management Service.

To assist it the Committee will utilise the work of scrutiny and other assurance services including NHS Wales Internal Audit and Audit

Wales, but will not be limited to these audit functions. It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

4.2 Risk Management

The Committee will seek assurance that there is an effective framework for the management of strategic, clinical and operational risks i.e. those risks likely to directly impact achieving the Health Board's IMTP and strategic objectives, and that the effectiveness of the framework is regularly reviewed.

The Committee will consider and recommend to the Board approval of a risk management approach and annually any required changes to the risk management framework.

4.3 Effective Assurance

The Committee's programme of work will be designed to provide assurance that:

- There is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;
- There is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;
- There is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through consideration by the Quality and Patient Safety Committee
- There are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees
- The work carried out by key sources of external assurance, in particular, but not limited to the Health Board's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity supports and informs (but does not replace) internal assurance activity
- The work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the

organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;

- The systems for financial reporting to the Board, including those of budgetary control, are effective; and that
- The results of audit and assurance work specific to the Health Board, and the implications of the findings of wider audit and assurance activity relevant to the Health Board's operations are appropriately considered and acted upon to secure the ongoing development and improvement of the organisation's governance arrangements.

4.4 Access

The Head of Internal Audit and the Auditor General and his representatives shall have unrestricted and confidential access to the Chair of the Audit Committee at any time, and vice versa.

The Committee will meet with relevant auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

5. Membership

5.1 Members

The Committee shall comprise of four (4) members:

Chair:	Independent member of the Board
Vice Chair:	Independent member of the Board
Other Members:	Two other independent members of the Board *[one of which should be the Independent Member (Finance)]*

The committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

The Chair of ABUHB shall not be a member of the Committee.

5.2 Attendees

Other officers of the Health Board will attend:

- Chief Executive / Accountable Officer

  The Chief Executive should be formally invited to attend, at least annually, to discuss the process for assurance that supports the

Annual Governance Statement and the Annual Quality Statement along with other public disclosure statements.

- Director of Finance & Performance
- Board Secretary
- Head or individual responsible for Clinical Audit, as appropriate although routine reporting would be via the Quality and Patient Safety Committee
- Local Counter Fraud Specialist
- Other Executive Directors will attend as required by the Committee

Non-ABUHB attendees:

- Head of Internal Audit
- Representative of the Auditor General

Others by invitation

The Committee Chair may invite the Chair of the organisation, any other Health Board officials and / or any others from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

5.3 Member Appointments

The membership of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair, taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office.

During their period of appointment a member may resign or be removed by the Board.

Co-opted external committee members' terms and conditions of appointment, (including any remuneration and reimbursement) are determined by the Board, based upon the recommendation of the Health Board Chair and on the basis of advice from the Health Board's Remuneration and Terms of Service Committee.

6. Support

6.1 Secretariat

Secretariat arrangements will be determined and arranged by the Board Secretary.

6.2 Advice and Member Support

The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of organisational development for committee members as part of the Health Board's overall OD programme developed by the Director of Workforce and Organisational Development.

7. Committee Meetings

7.1 Quorum

At least two of the selected members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

7.2 Frequency of Meetings

Meetings will be held at least quarterly plus one meeting to formerly agree the accounts and otherwise as the Chair of the Committee deems necessary – consistent with the Health Boards plan of Board business.

7.3 Withdrawal of individuals in attendance

The Chair may ask any or all of those who normally attend but who are not members of the Committee to withdraw to facilitate open and frank discussion of particular matters (an In Committee meeting).

7.4 Record of the Committee Meeting

A record of the meeting will be presented as notes and action points.

7.5 Public Meetings

The Committee will routinely meet in public.

8. Relationship and Accountabilities with the Board and its Committees

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:

~ Joint planning and co-ordination of Board and Committee business

and

~ Sharing of information

In doing so, it will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Health Board's overall system of assurance.

The Committee shall embed the Health Board's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

9. Reporting and Assurance Arrangements

The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of committee minutes and written reports throughout the year;
- Bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;
- Ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

The Committee shall provide a written, annual report to the Board and the Accountable Officer on its work in support of the Accountability Report, the Annual Governance Statement and the Annual Quality Statement, specifically commenting on the adequacy of the assurance arrangements, the extent to which risk

management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the committee's self-assessment and evaluation.

The Board may require the Committee Chair to report upon the Committee's activities at public meetings or to community partners and other stakeholders, where this is considered appropriate, e.g. where the Committee's assurance role relates to a joint or shared responsibility.

The Board Secretary, on behalf of the Board, shall oversee a process of annual self-assessment and evaluation of the Committee's performance and operation including that of any sub committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

10. Applicability of Standing Orders to Committee Business

The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

11. Review

These terms of reference shall be reviewed annually by the Committee with reference to the Board.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Audit, Finance & Risk Committee Thursday 8th April 2021 Agenda Item: 2.1

Aneurin Bevan Audit Committee

Muskulo Skeletal Pathway Redesign Programme 2021/22

Executive Summary

The Muskulo Skeletal (MSK) Pathway Redesign Programme has been identified as a strategic opportunity and priority for ABUHB to improve patient care outcomes, equity of access and efficiency, thus improving 'Value'.

The programme will review the entire 'end to end' pathway in stages; its objective is to re-design the service model into a public health informed, evidence based 'Perfect Gwent MSK' model, starting with referral and triage processes.

A refreshed programme governance structure was agreed by the programme lead, the Director of Therapies and Health Science in November 2020 with a commissioning approach built into the programme design.

The group structures include:

- Programme Board (scrutiny & commissioning role)
  - Project Implementation Group (Provider proposal oversight)
    - With 3 sub-groups:
      - Service Modelling Group
      - Clinical Advisory Group
      - Resources Group

Since November 2020 the impact of Covid-19 has resulted in limited progress, however the Resources Group has made excellent progress in ascertaining the baseline of MSK services provided in ABUHB and early observations identified.

The next steps are to further develop clarity on orthopaedic pathways and utilise the observations from the baseline pathway analysis and data sets, and inform the proposals being developed by the Service Model Group to create the 'Perfect Gwent MSK' model.

Regular progress reports will be provided to the Audit Committee.

The Audit Committee is requested to note:

- the refreshed inclusive programme governance structure for the MSK Programme
- the Programme Plan
- the progress to date by the Programme Groups to form baseline pathway mapping
- the next steps for the Programme

The Board is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			√
Note the Report for Information Only			
Executive Sponsor: Peter Carr, Executive Director of Therapies and Health Science			
Report Author: Rob Holcombe, Deputy Finance Director			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Committee Name]**	
Date of the Report:			
Supplementary Papers Attached: Appendices 1,2,3,4A,4B			

Purpose of the Report

To provide the Audit Committee with an update on the status of the ABUHB Muskulo Skeletal (MSK) Pathway Redesign Programme.

Background and Context

MSK improvement was identified by the Board as a strategic opportunity and priority for the 2020/21 IMTP.

Programme Governance

The programme was refreshed in November 2020. It was re-established to ensure there is clarity of aims, an inclusive and transparent approach and a mutually agreed multi-professional input to re-design an evidence based service model pathway(s). The aim is to deliver better patient outcomes, improved equity of access and improved efficiency in service delivery.

The programme will review the entirety (end to end) of the MSK pathway from an 'upstream' public health perspective, through the primary, community and acute sectors and discharge or self-care continuum. The objective is to re-design the service model into the 'Perfect Gwent MSK' model, starting with the referral and triage processes.

The programme governance structure is attached as appendix 1.

All key services have been invited to participate including:

Physiotherapy	Orthopaedics	Podiatry
Rheumatology	Radiography	General Practice
Workforce	Finance	Performance
Commissioning	Value	Weight Management

The group structures include:

- Programme Board (scrutiny & commissioning role) – Chair Peter Carr
  - Project Implementation Group (Provider proposal oversight) – Chair Sandra Mason
    - With 3 sub groups:
      - Service Modelling Group – Chair Collette Kiernan
      - Clinical Advisory Group – Chair Gareth Roberts
      - Resources Group – Chair Rob Holcombe

In addition, a dedicated programme lead (S.Mason) and a dedicated senior physiotherapist (S.Haworth Booth) with support from Finance (F.Davies) will support the programme.

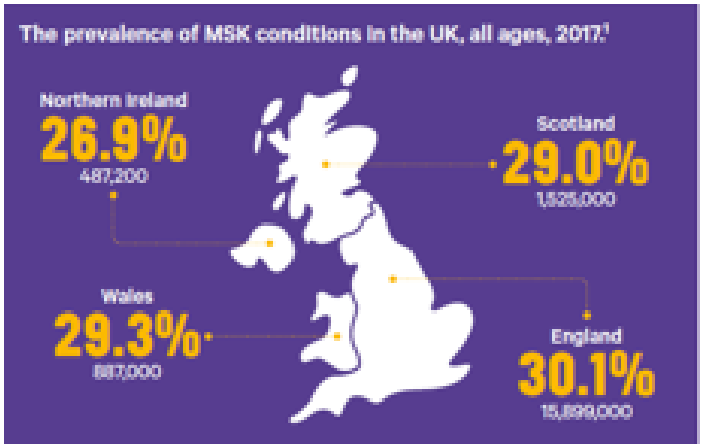
The impact of Covid-19 has meant limited development of the programme, however the Resources Group has made excellent progress in ascertaining the baseline of MSK services provided in ABUHB, this is outlined in more detail below.

Context – Population Health Determinants

According to national data published by Versus Arthritis, the scale of the MSK problem in the UK is such that 22% of the heath burden in the UK is attributed to MSK conditions, and 1 in 3 people have an MSK condition, the prevalence of which increases with age, and is inked to deprivation. By 2030 it is estimated that 40% of the working population will have a long term MSK condition.

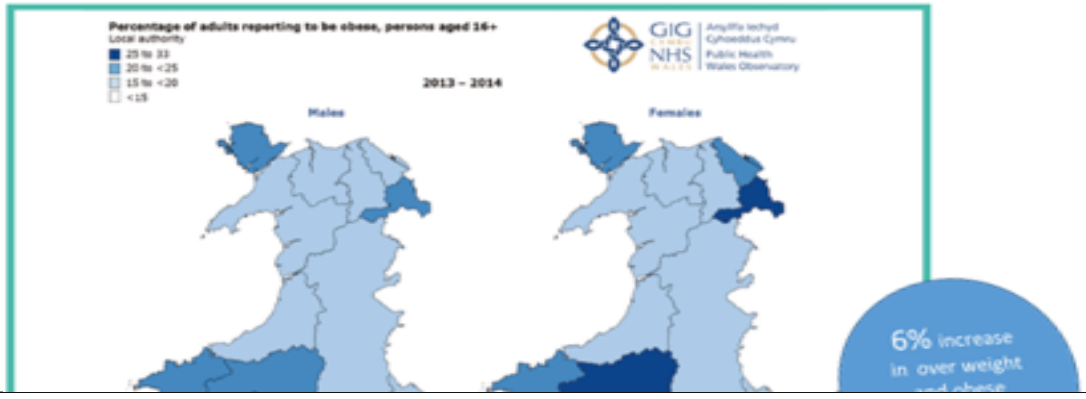
Causes of MSK ill health across the life course are:

- Maternal health
- Low birth weight
- Eating disorders
- ***Obesity – key factor affecting MSK health***
- Smoking
- ***Poor physical activity – key factor affecting MSK health***
- Poor nutrition



Incidence is linked to levels of deprivation, with inactivity and obesity being key factors affecting MSK health. The heat map below shows the comparative high level of obesity in the disadvantaged communities of North Gwent, when compared to the rest of Wales.

FIGURE 10: Percentage of adults reporting to be obese, persons aged 16+ years, 2013-14



Right sizing the service to address the population needs of the various socio economic communities in Gwent will need to be considered. This is consistent with the:

- ABuHB IMTP priority areas and Clinical Futures principles to reduce inequalities and to support people 'closer to home' by enhancing support to stay healthy, and
- the WG guidance on 'A More Equal Wales: the Socio-economic Duty' which requires public bodies, to consider how their decisions might help reduce the inequalities associated with socio-economic disadvantage.

Part of the work of the Programme will be to understand the future impact of such Public Health interventions on the future demand for MSK services.

The Programme Plan is included as appendix 2.

Assessment and Conclusion

The Programme groups work and achievements to date are detailed below:

Resources Group Progress

The Resources Group has taken a value based care approach to the project objective, mapping pathways, metrics, workforce and costs along those pathways. The multi-professional Resources Group has met regularly since November and although there was initial hesitation to participate, engagement with the membership enabled active participation.

The key first objective of the group was to produce a baseline analysis for ABUHB services, using 2019/20 as the base year. It identified:

Patient/service Pathway summaries and detailed 'swim lanes' for each major pathway into MSK services:

- Physio (5)
- Orthopaedics (5)
- Podiatry
- Rheumatology
- Radiography
- Primary Care

Metrics aligned to those pathways in terms of:

- Referrals/Capacity/Demand/Activity
- Staffing deployed
- Financial resources utilised

Comparisons on a borough basis of:

- Services Available
- Resources utilised
- Population Usage

- Access to MSK assessment, treatment and secondary care services

The service managers and value pathway mapping lead have successfully created a series of baseline MSK service pathways, at a summary and detailed patient 'swim lane' level – examples of which are included in Appendix 3 for reference. These will be used to review current practice and map metrics to inform proposed changes.

Service Modelling Group Progress

The Modelling sub-group has had one formal meeting. This has been followed up with a number of individual meetings between the Chair of the sub-group and MSK leaders within Scheduled and Unscheduled care to 'join up' change activity and discuss potential pathways that can be used to standardise referral criteria between services.

The sub group has reviewed the current evidence base for management of MSK conditions, public health indicators for the population of ABUHB, benchmarked commissioning standards, where they exist, and also delivery models for therapy services across Wales.

This work has been used to quality assure work previously completed on a potential new operational model for MSK single point of access for therapies. This quality assurance, together with additional drivers related to the developing model of Urgent Primary Care in Wales and ABUHB Clinical Futures ED and minor injuries strategy, has led to some positive amendments to the draft model.

The evidence base identifies clear opportunities for improvement that could be captured as part of the proposed draft model: enabling ABUHB to comply with National guidance whilst also aligning with ABUHB strategic requirements for Primary Care, Urgent Care and Scheduled Care services. Final information from the Resource Group on system wide activity and scheduled care processes will be used to finalise the potential measureable benefits and potential requirements to 'right size' each element of the overall pathway.

The Group has discussed the development of 'entry criteria' for a 'direct to T&O' element of the pathway to ensure there are no delays to high risk / definitive surgical patients entering the T&O service. All others will feed through the community Therapies element of the pathway. This work will ensure clinical governance and open unobstructed flow of the correct patients directly to T&O whilst filtering those who will benefit from self-help, supported self-help and Therapies input through the single point of access that is the first step in the proposed community pathway.
The next steps for the Modelling Group are to review the information and advice from the resource group and amend service development, particularly with regard to the expectations for referral criteria between services. This will lead to the consideration of how to operationalise the pathway and the impact this will have on resources, workforce and reporting structures. It is anticipated that this work will be undertaken and completed in Quarter 1 (2021/22).

The following outputs and observations have been produced from the work of the Resources Group

Population Service profile

The table below summarises the available MSK services across Gwent, provided by ABUHB and commissioned from C&V and CTM;

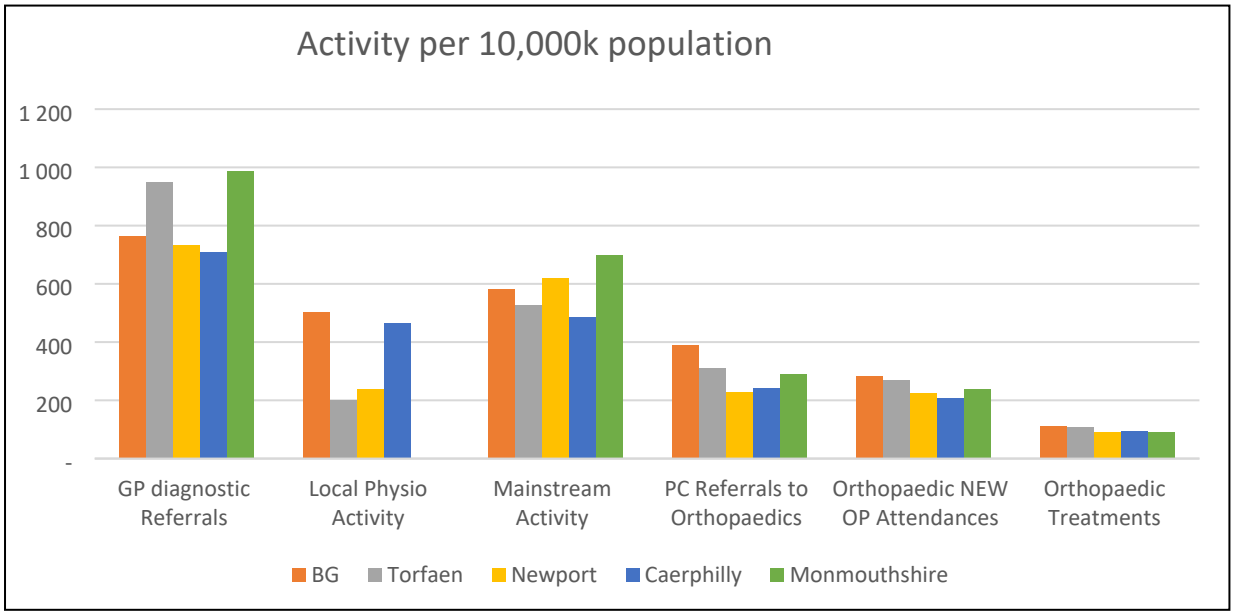
MSK Service/Metric	BG	Torfaen	Newport	Caer	Mon	Gwent
GP MSK Consultations/annum	46,876	58,312	95,244	111,688	52,529	**364,648**
Prescribed drug units	64,591	92,421	107,648	147,188	80,246	**492,094**
	National evidence suggests 14% of these consultations relate to MSK consultations					
PC Direct Access Clinic (DAC) Consultations	1,821	1,958	2,735	0	0	**6,514**
	Band 6: Assessment & simple treatment – no wait; 15 minute appointment					
PC First Contact Practitioner (FCP) Consultations	1,777	0	1,052	8,707	0	**11,536**
	Band 7: Expert triage, onward referral or treatment – no wait; 20 minute appointment					
MSKi Specialist Triage & Treatment Consultations	173	1,105	1,114	1,314	679	**4,385 PC 1,775 Other**
	Expert assessment, triage and onward referral/ treat. Accessible to all Gwent residents. Delivered from YYF, STW, County Hosp. WT = max 14 weeks for Routine; 10 working days for urgent					
Mainstream Physio New Consultations	4,541	5,390	10,250	10,507	8,039	**38,727**
	Assessment, Triage, Treatment – 30 to 60 minute appointment. WT max 14 weeks for routine; 10 days for Urgent.					
Podiatry	**4,200 New Out Patients per Annum – delivered across all 5 boroughs**					
Orthopaedic Per annum: **OP slots** **Treatments** **WTE**	2,030 OP 791 Treats	2,610 OP 1,047 Treats	3,556 OP 1,467 Treats	3,920 OP 1,774 Treats	2,432 OP 906 Treats	**Elective** **14,548 OP** **5,985 Treats** **431wte**
Rheumatology per annum: **New OP Att** **FUp OP Att** **Drugs Spend** **WTE**	271 1291	337 1640	475 2520	576 3549	332 1458	**1,991** **10,458** **£3.318m** **25.43 wte**
Commissioned Orthopaedic services (C&V and CTM) **Outpatients** **Treatments**	265 36	251 37	484 73	1867 317	164 26	**£2.1m elective** **3031** **489**

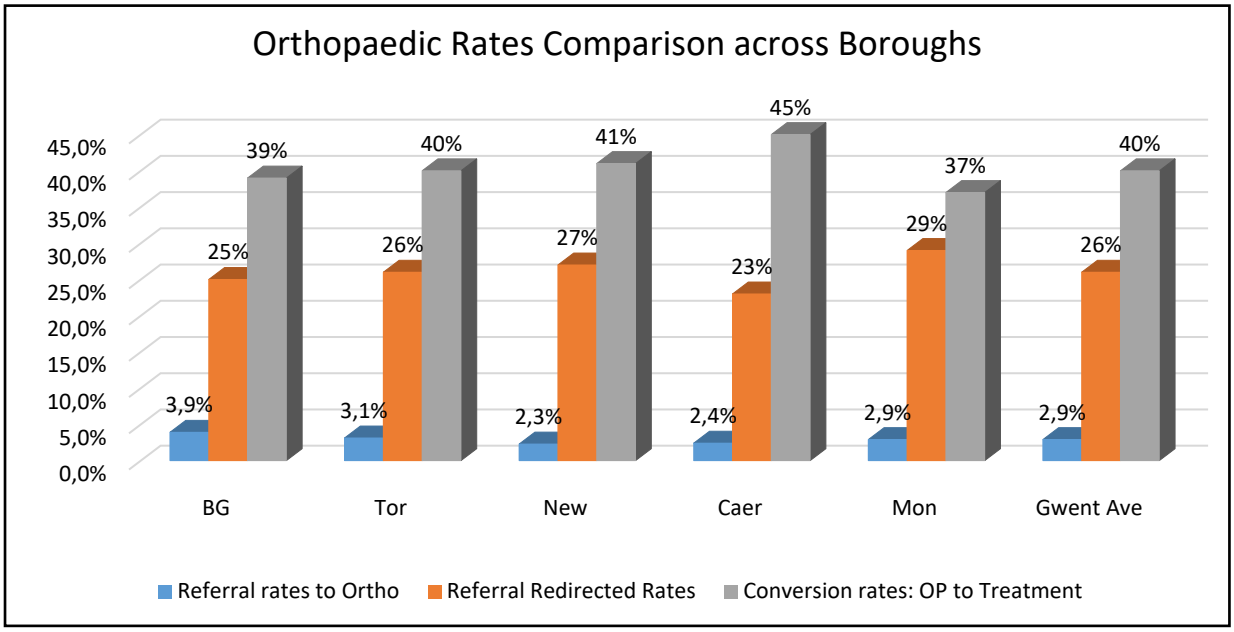
Summary of initial observations

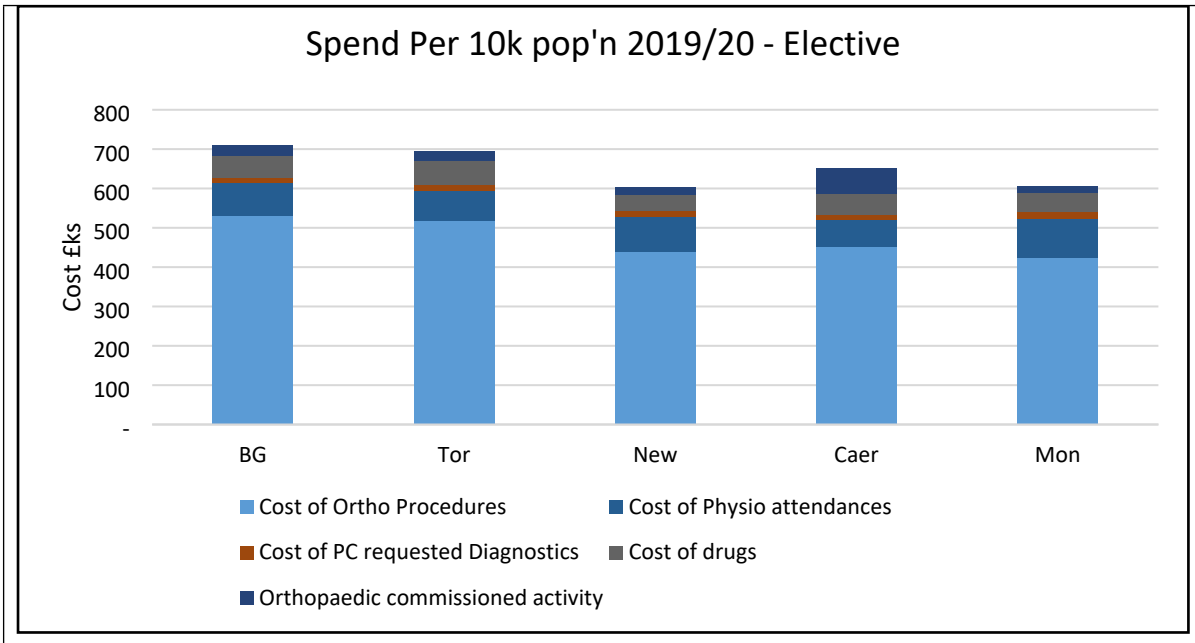
- MSK services serve a population of 615,727 within South East Wales.
- In 2019/20 ABuHB spent £76.9m on MSK related activity, which is 5.6% of its overall spend. The average cost per head is £124.32, compared to an All Wales average of £125.55.
- GP's provide approximately 364,000 MSK patient consultations per annum, with a spend of £3m on prescribed medicines per year. They refer 79,000 MSK patients onto alternative services every year.

- There are 5 access routes for Physiotherapy across ABUHB & these are inconsistent across ABUHB boroughs and potentially inequitable in terms of local access and waiting times.

The following Graphs present a summary of borough MSK elective activity and financial metrics across Gwent:







Appendices 4A and 4B provide a comparative analysis of the utilisation of available services across each borough, observations are set out below:

Appendix 4A Key Observations:

- There is variation in local provision of MSK expert physiotherapy assessment across the boroughs, ranging from 3.5wte in Caerphilly and 0wte in Monmouthshire. This results in patients, dependent on where they live, waiting different times (next day or 14 weeks) for differing levels of assessment, pain management and diagnostic and secondary care referral.
- ROTT rate to MSKI is 53%.
- WTE Cost per average physio attendance ranges from £22.02 (FCP) to £63.20 (MSKI).
- Caerphilly has the lowest Primary Care ROTT rates for referrals to Rheumatology and Orthopaedics.
- Caerphilly has the highest rate of OP conversion to treatment, from first OP attendance.
- DNA rates to mainstream Physiotherapy across the boroughs range from 5.1% in Monmouthshire to 10% in Newport.
- Self-referrals to mainstream physio does not happen in Caerphilly or Monmouthshire – it is unknown whether this is a lack of need or poor data.
- The ROTTs in Rheumatology are high, at circa 40%. The comparison across Wales and the UK is unknown and therefore, this may be an expected rate.
- The lowest spend per head on MSK related drugs in primary care is in Newport and Monmouthshire; different prescribing regimes may account for this.

Appendix 4B Key Observations:

GP Managed cases:

- Newport is well below its expected percentage share of drug spend and has the lowest cost per head.
- Monmouthshire has a comparatively low cost per head.

Physiotherapy (Local service):

- Highest local physio activity is in Blaenau Gwent and Caerphilly; no activity in Monmouthshire.
- Where there is a local physio service, Torfaen has the lowest spend per 10k population and the Health Board spends more per 10k population in the 2 most deprived areas, Blaenau Gwent and Caerphilly.

Physiotherapy (MSKI):

- Torfaen has a 10% greater than population share level of referrals to the MSKi service. The opposite has occurred for BG, being almost 10% lower than fair shares.

Physiotherapy (Mainstream):

- Spend per head is based on total activity in mainstream Physio, which includes referrals from Orthopaedic consultants and other departments. In this context the two most deprived boroughs have 2 of the lowest spends per head.
- Blaenau Gwent has by far the greatest number of self-referrals into the mainstream service, with Caerphilly and Monmouth having none. This is a further example of unwanted variation in referral pathways and access to service.

General observation - Boroughs with a local physio service have no wait to physio assessment, however, Monmouthshire residents may wait 14 weeks.

Diagnostics – Radiology:

- Torfaen and Monmouthshire have the highest number of GP diagnostic referrals per head and the highest spend per head.
- This is because these 2 boroughs have more than their population share. The 2 most deprived boroughs are below their percentage share.

Orthopaedics (ABUHB Acute elective):

- Caerphilly and Newport are well below the percentage share of total GP referrals.
- Caerphilly and Newport have the lowest OP activity per head, but overall Newport, Caerphilly, Torfaen have highest percentage of referrals accepted as OP.
- When analysing by joint, Blaenau Gwent, Torfaen and Monmouthshire consistently have greater proportion of first out-patient consultations than population shares. These boroughs have the least amount of local physio input.

		BG	Torfaen	Newport	Caer	Mon
% Popn shares		**12%**	**16%**	**26%**	**30%**	**16%**
% of OP First Attendance	Spines	14%	20%	26%	29%	12%
	Hip & Knee	14%	18%	24%	27%	18%
	Shoulder	16%	18%	22%	24%	21%
	Hand	13%	17%	25%	25%	20%
	Foot&Ankle	13%	17%	26%	30%	14%

- However, Caerphilly has the highest % of out-patient activity proceeding to treatment from first appointment.

% Orthopaedic OP Activity Proceed to Treatment	BG	Torfaen	Newport	Caer	Mon
Spines	20%	10%	14%	17%	15%
Hip & Knee	29%	34%	33%	37%	32%
Shoulder	22%	24%	22%	21%	22%
Hand	39%	39%	39%	46%	36%
Foot&Ankle	26%	25%	21%	27%	25%

- Within ABUHB services the Health Board spends more on Orthopaedic treatments per head in Torfaen and lowest in Monmouthshire.

Overall observation – there is some evidence that where there is immediate local expert physiotherapy assessment and management (eg Caerphilly), then referrals into Orthopaedics is lower than expected, with a high degree of conversion from out-patient first appointment to treatment. Cost per head of treatments is also lower in comparison. The opposite is seen in boroughs such as Blaenau Gwent and Monmouthshire, where there is little or no local physiotherapy service.

Value Based MSK Projects

The following projects are planned to be progressed and will form a key part of redesigning a value based future pathway for ABUHB. Mapping a sample of individual patients along the swim lane service pathways to determine how closely patient care actually follows the assumed service model. Specific focus will be on:

- Lower Back Pain
- Shoulder Surgery
- Acute orthopaedics
- Physiotherapy patients flows

Website Progress

An important element of the MSK transformation programme is the design and establishment of an MSK patient information website. This is intended to be the primary source of MSK information and advice for the Health Board population with content devised by MSK experts. The website will be a positive experience of health promotion, well-being and condition prevention, using a multi-media approach. The website will be a user-friendly process from self-help through to expectation management. There will be a route to email a generic email address for further advice if required.

Conclusion

The work by the programme so far has focussed on baseline clarity along patient pathways and the associated metrics and comparative measures. The Resources Group outputs identified observations for consideration to improve equity of access and develop a consistent service offering across all elements of the MSK pathway in Gwent.
Progress has been made with developing a pilot website solution and discussions have started on future model pathway design.
Next steps include progressing future pathway designs from an evidenced, value based patient outcome focussed approach, considering the best models to be applied across Gwent on a consistent basis, reducing variation and designing a model that is sustainable, more efficient and manages demand appropriately, whilst ensuring equity of access across the whole population served by ABUHB.

Recommendation
The Audit Committee is requested to:

- Note the refreshed inclusive programme governance structure for the MSK Programme
- Note the Programme Plan
- Note the progress to date by the Programme Groups to form baseline pathway mapping
- Note the next steps for the Programme

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The risks identified include: • Areas identified would either improve patient care or should not worsen outcomes for patients • The benefits of new systems should outweigh the costs incurred
Financial Assessment, including Value for Money	The costs of MSK services are analysed in the report
Quality, Safety and Patient Experience Assessment	Compliance with national guidelines.
Equality and Diversity Impact Assessment (including child impact assessment)	E&DIA will be performed where appropriate.
Health and Care Standards	This paper links to Standard for Health Services One – Governance & Assurance. Compliance with national guidelines.
Link to Integrated Medium Term Plan/Corporate Objectives	The IMTP identifies MSK pathway redesign as a strategic priority.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*This section should demonstrate how each of the '5 Ways of Working' will be demonstrated. This section should also outline how the proposal contributes to compliance with the Health Board's Well Being Objectives and should also indicate to which Objective(s) this area of activity is linked.*
	Long Term – yes
	Integration – yes
	Involvement – yes
	Collaboration – yes
	Prevention – yes
Glossary of New Terms	*N/A*
Public Interest	*Changes to services will be consulted upon as required*

Appendix 1

Programme Governance Structure

MSK PROGRAMME- Terms of Reference

1. Vision and Purpose

The Board will be responsible for the delivery of the MSK Programme, as approved by Director of Therapies. This will be achieved through the application of the Value Based Healthcare and Prudent Healthcare principles, utilising the WHC (2018) 025 "Improving Value through Allocative and Technical Efficiency".

The aims and objectives are to develop an integrated MSK service across ABUHB, through:

- Identifying the current and future need of the ABuHB population
- Understanding the current service pathways and performance, and the resources deployed
- Identifying and confirming the evidence to inform future best practice pathways
- Capturing patient outcome and quality measures
- Identifying measurable benefits, qualitative and quantitative, to support and justify the pathway change
- Development of a self-management resource across the HB (eg via website)
- Consideration of PH interventions and potential impact on need and demand
- Development of alternative care pathways and services that improve performance and outcomes. Including consideration of :
    - a Single Point of Triage(SPT),
    - assessment by a multidisciplinary hub, (diagnostic and/or treatment)
    - referral to the most appropriate clinician/service/place/time.
- Standardisation of referral criteria/documentation and protocols
- Right sizing for local population needs within Gwent.

2. Roles and Responsibilities – PROGRAMME BOARD

The role of the Programme Board is to act as "the commissioner", to scrutinise the design and delivery of the MSK transformation, and provide oversight of the achievement of the objectives within the timeframe and parameters required**.** The role and responsibilities of Programme Board members is as follows:

Programme Board Member	Name	Role
Executive Sponsor, Chair	Peter Carr	Be ultimately responsible for the MSK Transformation Programme. Ensure the MSK Transformation Programme remains focused on achieving its objectives and realising the benefits in line with timetable.

		Be responsible for the expenditure within the delegated budget.
Programme Lead	Sandra Mason	Ensure delivery of products for the Programme; manage the implementation of the delivery plan for the programme; provide monthly progress reports to the Programme Board.
Chair of the Clinical Advisory Group	Gareth Roberts	
AMD / MSK Lead Clinician	Dave Minton	To lead the clinical effectiveness, quality, patient safety and experience for the service model
Therapies Clinical Director	Collette Kiernan	To confirm the therapy service model
Divisional Director representatives – F&T, SC, PC&Comm.	Claire Lipetz, Tom Morgan-Jones, Liam Taylor	Objective clinical assessor of the programme design and products, and the impact on operational effectiveness, quality, patient safety and experience. To scrutinise and consider the recommendations from the Implementation Project Group.
Commissioning Lead	Rob Holcombe	Overall business/ planning advice, and resource and benefits analysis.
Value Based Lead	Adele Cahill	To advise on patient outcome capture, systems solutions, monitoring and reporting for improvement.
IT/Informatics representative	Mike Ogonovsky	ICT development, system solution, impact and benefit analysis.
Secretariat	Jane Daly	
Following to be co- opted if required:		
Facilities		Professional advice
Engagement/Comms		
Workforce		
Information		

Note: Members must make every effort to attend. In the event that a member is unable to attend, a deputy with equal authority to act must be agreed with the Chair, in advance of the meeting. If no deputy is available then a written review of the items on the agenda should be forwarded in advance of the meeting.

Programme Board will:

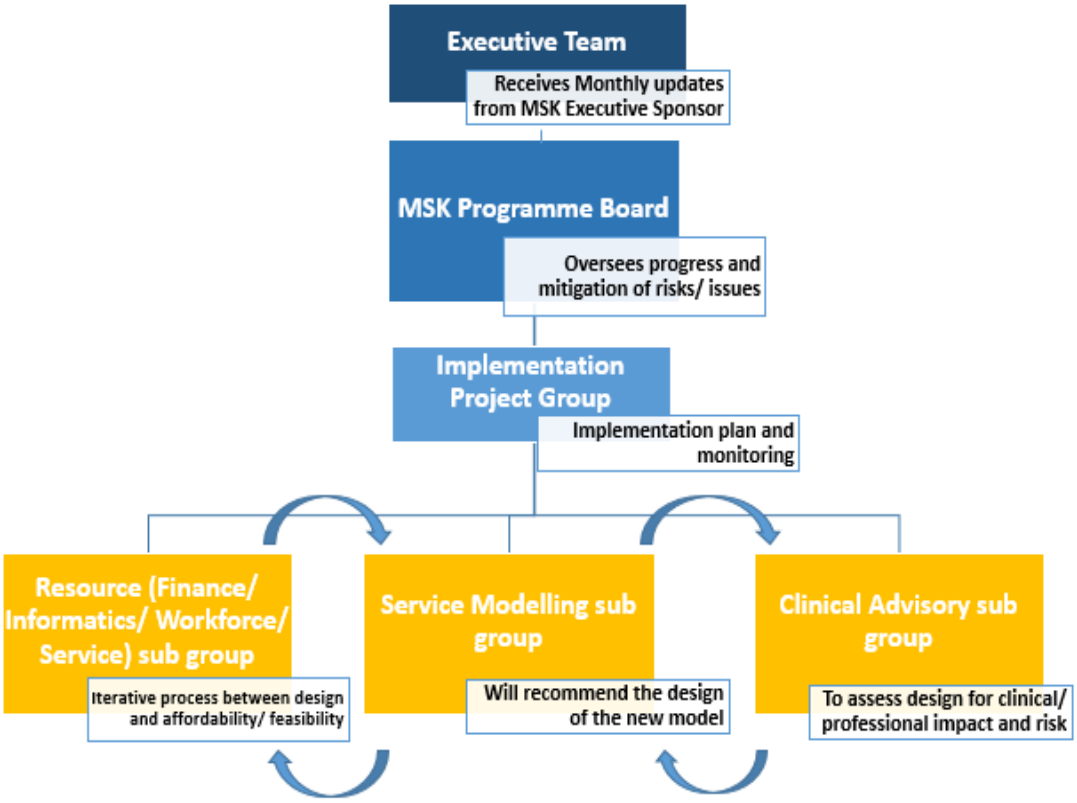
- Consider, scrutinise and agree recommendations as part of the business case for change that is received from the Implementation Project Group.
- To ensure the achievement of the programme aims and objectives.
- Manage the design and delivery of the MSK transformation, within timeframe and parameters required,
- Be supported by, and receive the following reports from the Implementation Group:
    - progress of the overall programme against delivery timetable/ milestones/products,

- recommendations/ options for mitigating actions required to ensure delivery, and
- escalation of risk log items for the programme to Executive Board, with recommendations for mitigating risks.

- Agree actions/ escalation to facilitate progress to implementation.
- Advise the Executive Sponsor/ Executive Board with regards financial impact and commitments, within the existing financial procedures.

The Programme Board will be supported by a number of subgroups. The hierarchy for reporting is illustrated in the chart below, and the roles and responsibilities for these subgroups is set out in Sections below:

MSK Programme Board Governance & Reporting Hierarchy



The Programme Lead and Project Manager roles will provide support and focus for the Programme Board and all of the sub groups, by:

- facilitating meetings and agendas,
- producing programme plans,
- maintaining action logs and risk registers, and
- providing standardised documentation.

3. Roles and Responsibilities – IMPLEMENTATION PROJECT GROUP

The role and responsibilities of the Implementation Project Group will include developing the "provider" response as a business case for change, for an improved reconfigured MSK service for ABuHB.

Membership is as follows:

Implementation Group Member
Programme Lead
Orthopaedics Specialty representative
Value Clinical Lead
Chair of the Clinical Advisory Sub Group
Chair of the Resources Sub Group
Chair of the Service Modelling Sub Group
Head of Therapies
AMD / MSK Lead Clinician
Head of Strategic Financial Planning
WF Business Partner for Therapies
Informatics
Project Manager
Following to be co-opted if required:
Facilities
PC&Comm Divisional management
SC Divisional management

Implementation Project Group will:

- Encompass the improvements proposed for a new MSK service, in a business case for change
- Be responsible for making recommendations to the Programme Board in order to delivery Programme objectives.
- Receive updates and progress reports from the 3 supporting sub groups.
- Monitor the progress of the overall programme against delivery timetable/ milestones/products.
- Agree mitigating actions required to ensure delivery.
- Maintain and monitor the risk log for the overall programme and agree mitigation actions and/or recommendations to Sub groups and/ or Programme Board, if required.
- Under the chairmanship of the Programme Lead, individuals may be asked to contribute to and/or produce monthly progress reports, with recommendations, to the Programme Board.

4. Roles and Responsibilities – SERVICE MODELLING SUB GROUP

This subgroup is responsible for identify the current model pathway & designing the new service model pathway, based on:

- Evidenced best practice,
- agreed ABuHB strategic principles, and
- agreed planned benefits.

Membership is set out in the following table:

Service Modelling Sub Group Membership
Clinical Director of Therapies, Chair
Programme Lead
Head of Physio
Programme Advisor
T&O clinical representative
AMD / MSK Lead Clinician
Value representative
Weight Management
Podiatry
CRT
Workforce
Finance
Information
Project Manager

The Group will:

- Undertake a desk top and site based research of evidenced based MSK models, that have been successfully implemented in the UK, and also demonstrate performance/outcome improvements
- Identify and articulate the 'problem/s' that exist in the current AB service, when compared to best practice
- Liaise with the Resource Sub Group and Clinical Advisory Sub Group to:
    - Initially quantify baselines and comparators for the current MSK service and its 'problem' areas, and later, through a series of iterative cycles, to
        - Consider Public Health interventions and potential impact on need and demand, and
        - Right sizing of new service for ABuHB need/demand
- Use evidence to design 'best practice' model, and how this could 'fit' within AB.
- Identify measurable benefits, qualitative and quantitative, to support and justify the pathway change
- Develop a self-management resource across the HB (eg via website)
- Develop and standardise referral criteria/documentation and protocols

- Report monthly to the Implementation Group.
- Maintain the risk register by recording, managing risks where possible and escalating to Implementation Group when necessary.
- Ensure agenda and papers are available 3 days prior to an Implementation Group meeting.
- All products emerging from this sub group are reviewed and approved by the Implementation Project Group, for recommendation to the Programme Board.

5. Roles and Responsibilities – CLINICAL ADVISORY SUB GROUP

This sub group of subject matter experts is responsible for advising on, influencing and assessing the proposed changes for clinical / professional impact and risk. It will provide expert review of the newly designed service to provide assurance on its appropriateness and safety to meet patient's needs and prevent harm, before rolling out the changes in the respective areas.

Report monthly to the Implementation Project Group.

Membership is set out in the following table:

Membership - Role
Value Based HC clinician
Clinical Director T&O
CD Rheumatology
Public Health Lead
Therapies Lead Clinician
AMD / MSK Lead Clinician
Head of Physio
Programme Lead
Project Manger

6. Roles and Responsibilities – RESOURCE SUB GROUP

This sub group is responsible for producing the baseline for the current model's activity, performance, workforce and financial analysis, using data and intel produced/ directed by the Programme Lead. It is also responsible for providing the resource implications and impact of the new model pathway.

Report monthly to the Implementation Project Group.

Membership is set out in the following table:

Membership - Role
Deputy Director of Finance, Chair
Programme Lead
Service representatives - Therapies
Service representatives - Orthopaedics
Information representative
Workforce representative
Finance representatives
Primary Care representative
Value representative
Project manager

7. Method of Operating

Programme meetings will be arranged to take place on a 4 week cycle. Special meetings maybe called at any time at the discretion of the Chair. Meetings of the Sub Groups will be dictated by the frequency of Board meetings and product/milestones.

It is anticipated that the MSK Programme Board will meet for 12 months, to allow for evaluation. The ToR will be kept under review and amended as necessary.

All decisions will be made by a simple majority and the quorum for the Programme Board will be the chair/ vice chair and 4 members.

All papers will be submitted to the Programme Lead/ Project Lead one week in advance of the Programme Board meeting.

Agenda and papers are available 5 days prior to a Programme Board meeting.

Standing Agenda items:

- Minutes from the previous meeting
- Agenda
- Recommendations from supporting groups
- Actions log
- Update against agreed Programme deliverables
- Risk log/register
- AOB

8. Resourcing

A programme team has been established with an Executive Sponsor identified as the Director of Therapies. Members of the MSK programme are expected to resource and deliver their respective actions utilising divisional resources.

9. Governance

The Programme Board will sit within, and be subject to, the Health Board structures, standing financial instructions and procedures.

It will be required to make monthly progress reports to the Executive Team/Board, to ensure that all corporate delivery framework requirements are met, and any conflicts resolved.

Appendix 2

MSK Programme Plan

2.1b MSK Project Plan.xlsx

Appendix 3

MSK Pathway Mapping

Detailed MSK Pathway 'Swim Lanes'

MSK High level 0.9.pdf

Examples - Summary Level Pathway analysis

ABUHB MSK 'Pathway Story Board' Mainstream Physiotherapy Service

Background
The MSK physiotherapy service provides education, assessment and treatment for people with pain or dysfunction of bones, muscles, tendons, ligaments and joints. Physiotherapists are autonomous practitioners who facilitate and support self-management helping to promote independence and minimize episodes of ill health and disability developing into chronic conditions.
Referrals are for all MSK physiotherapy referrals across ABUHB across primary care, secondary care & post trauma (ED/MIU). All orthopaedic and rheumatology conditions are managed by the same team. MSK physiotherapy is a core component of physiotherapy practice and the service has high levels of junior rotational staffing and provides undergraduate and post graduate student placements.
Childrens MSK disorders are managed within the childrens physiotherapy service which is separate to the adult MSK physiotherapy team. Childrens physiotherapy for rheumatology is provided by UHW

Service delivery
Referrals are made into geographical departments based on patients home address
Departments are in NHH, YAB, County, MV, Chepstow, YYF, SWH, RGH
Patient can access treatment at most appropriate location for them (home or work)
All referrals are triaged by senior clinicians and are prioritised into appropriate timescales (urgent or routine), seniority of treating clinician and time needed for NP (60/30 mins)
Education, assessment & treatment is provided in a 1:1 and group settings depending on patient need & departmental space
All senior clinical specialist and clinical lead staff are able to act as non-medical requesters and if trained, provide joint and soft tissue injections

Referral criteria:
Referral criteria and urgent/routine prioritisation information are available at the following link:
http://howis.wales.nhs.uk/sitesplus/documents/866/ABUHB_F%26T_0477%20Protocol%20for%20the%20Prioritisation%20of%20Outpatient%20Referrals%20%28Physiotherapy%29_Issue%203.pdf

Capacity
Job plans for standardised non direct clinical time for team lead, Clinical Specialist and Team Lead roles
Set by templates within WPAS with agreed number of NP and follow up patients in dedicated clinic sessions
No bank staff availability to cover AL, SL, ML
Service agreements for capacity/WTE & utilisation agreed with TU

Referral	Demand	Assessment	Treatment/ diagnostics	Discharge
Referral in terms of Referral teams on WPAS	Demand in terms of Waiting list maintained and managed within WPAS	Data Sources Captured: All clinical documentation completed on paper records. All appointments on WPAS	Data Sources Captured: All assessment All clinical documentation completed on paper records. All appointments on WPAS	Data Sources Captured: Discharge numbers only on WPAS
Data sources not available:	Data sources not available:	Data sources not available:	Data sources not available:	Data sources not available: Discharge locations not recorded on WPAS

Performance measures:
Routine –14 wk standard for Therapies
Urgent – 10 working days

Service Feedback:
Positive:
High levels of patient satisfaction
Efficient prioritisation of referrals on same day of receipt
Good utilisation of skill mix
Presence in all ABUHB boroughs with knowledge of local GP teams
Needs Review:
To have direct control of referrals – to avoid unnec W/L additions
Poor referrals levels areas of ABUHB in comparison to National levels

ABUHB MSK 'Pathway Story Board' Mainstream Physiotherapy Service
Areas to improve Outcomes and Patient Experience 2019/20 data

Not children

Service in all HB areas by admin team for all physiotherapy services for that area

Time from referral to prioritisation = <24hrs

2019/20 RTT WTs & nos *
WG Tier 2 Max 14/52 wait
- Total no. referrals 2019/20 = 40053
- Max wait 19/20 = 16 weeks (March 2020)
- Mean wait 19/20 = 13 weeks

Exclusive short notice CNA 12,134 NP & Fup Slots/templates not closed properly (in capacity assumptions)

PROMs used in direct patient care and some specific projects (e.g. LBP & STarTBack)
PREMs 438 people reported on their experience following their physiotherapy appointment between October 2019 – January 2020. 95.4% or responders were happy (5%) or really happy (90.4%) with their experience.
Negative comments in regard to parking, signage, pre appointment information, late start time for appointments & poor state of department (County)

NP:Follow UP ratio 1:2.36

Overall DNA* = 9165 DNA Rate 8.00%
NP DNA = 2706 7.94% FUP DNA = 6459 8.02%

Referrals*	ROTTs*	Demand minus ROTT	Maximum theoretical Capacity	Actual Capacity	NP Activity of 2019/20 demand*	Outcome*	Investigations Required	FU Activity*	Outcome*
DEMAND 40053	4809	35244	NP – 53156	NP – 40090	31360 NP Att	Discharged 5260 Converted to FU 26084		74055 FU Att (each Att per PT)	19704 D/C from Service at year end

	Total Demand	ROTT	Demand minus ROTT	Overall DNA rate
Blaenau Gwent	4675	504	4171	8.6%
Caerphilly	10201	1136	9065	7.3%
Monmouthshire	8329	1254	7075	5.1%
Newport	11188	1338	9850	10.1%
Torfaen	5660	577	5083	8.5%

Outcome of NP Attendances*
20% are Discharged after First attendance on caseload.
The remaining 80% are converted to a FU Apt

Outcome of FU Attendances*
75% of Patients converted from New to FU were discharged at year end.
27 % were Discharged of Total FU attendances at Year End

Max staffing (higher than funded establishment) WTE 120.36 Clinical & Admin 82.8b

2019/20 Referral Source:*
- Primary Care = 17218
- Self Referral = 4019
- T&O = 17084
- Rheumatology = 290
- ED/MIU = 712

98.1% of referrals

2019/20 ROTTs*
Nos = 4809
RoTT by reason (4517 / 94 %)
- DNP = 2967 / 66 %
- Treatment no Longer required=753/17 %
- Inappropriate Referral = 497 / 11%
- Refused Offer of Apt = 300 / 6%

Discharge destinations : Unable to identify on WPAS

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* Activity and outcome data recorded onto WPAS April 2019 – March 2020
* Patient Experience measure by anonymised paper questionnaires completed by patients who attended the outpatient MSK departments between Oct 2019 - Jan 2020

ABUHB MSK 'Pathway Story Board' Primary Care

Background

General Medical Services are delivered by 74 GP practices in Gwent. Practices are run by Independent Contractors, with core funding allocated through the GMS contract and additional funding available via the Quality Assurance & Improvement Framework and delivery of Enhanced Services. Primary Care is increasingly bolstered by funding on a cluster basis (recurrent and non-recurrent) via NCN Funding, Transformation Funding and the Integrated Care Fund, designed to affect a sustainable shift of resources from secondary to primary care.

Access to primary care data is complicated due to the structure of data in EMIS / Vision and the fact that GPs are their own data controllers, with LMC, GPC Wales and NWIS required to agree any pan-practice release of data via Audit+.

Service delivery

The vast majority of MSK demand in primary care continues to be managed by GPs, with variable access to First Contact Practitioners and Direct Access Physiotherapy depending on practice willingness to adopt the model and provision of care by the Health Board. There is no single 'optimum' model for managing MSK in primary care, although NCNs have chosen to invest into supplementary physiotherapy capacity via NCN funds to test models.

There is evidence of significant variation in the management of MSK on a borough, cluster and even individual practice level. This is indicated via prescribing rates and referral rates for diagnostics and secondary care specialties.

Care Navigation has been introduced in primary care in an attempt to direct patients to the most appropriate professional in the first instance. Training has been provided to all GP reception staff.

Perceived Opportunities in Primary Care

- Develop web resources for direct access / self-referral to therapy provision where primary care can be bypassed safely
- Determine the optimum model of FCPs and DAP services and ensure equitable provision across Gwent, with sufficient capacity to make a meaningful impact on the overall scale of MSK demand in primary care
- Provide clarify for GPs on the referral criteria for CRTs, MSKI, Mainstream Physiotherapy, Podiatry, Orthopaedics and Rheumatology to ensure most effective use of resources; and / or
- Develop a single triage process where decisions on routing of MSK demand can be made by experts

Capacity

There are an estimated 391 GPs required in primary care based on the orthodox staffing model, with 12% of capacity potentially focused on stand-alone MSK conditions.

Implementation of the Transformation Model focuses on switching GPs for extended scope practitioners. Skill mix varies depending on practice staffing models and access to FCPs and DAP in each borough.

MSK-orientated capacity within practice typically consists a combination of reception staff (care navigation), GPs and First Contact Practitioners (Physio). Primary care capacity bolstered by Direct Access Physiotherapy which is available in 3/5 boroughs.

New Presentations	Encounters / Consultations	Treatment / diagnostics	Referral / Signposting	Completed Episodes
Presentations to primary care with a new MSK condition which begins a new episode of care	Number of times a practitioner encounters a patients as part of an MSK-related episode of care	Access to diagnostics tests (i.e. bloods, radiology) and prescription of medication or exercises	Onward referral or signposting for assessment or treatment	Conclusion of a specific episode of care in primary care with no firm plans for follow up
Data source not available: EMIS / Vision	Estimates based on staffing models per head of population	Medicines Prescribing (NWSSP), RADIS & LIMS	WPAS for receipting specialties	Data sources not available: GP practice system

Service Feedback:

Positive:

Needs Review:

ABUHB MSK 'Pathway Story Board' Primary Care
Areas to Improve Outcomes and Patient Experience Based on Variation

Area	Patient Population	Planned capacity for consultations in primary care *	Assumed number of MSK related attendances **	Mix of primary care additional support		Estimated MSK prescribing rates ^		Referral patterns from primary care +				
				FCP	DAP	Units	Cost	Radiology	Podiatry	MSK Physiotherapy	Rheumatology	Orthopaedics
Blaenau Gwent	71,491	46,835	5,620	249	255	9,085	£1,052	678	51	154	64	391
Caerphilly	187,155	42,626	5,115	465	-	7,864	£1,241	439	52	366	51	217
Monmouthshire	101,468	36,978	4,437	-	-	7,909	£765	665	47	561	56	290
Newport	158,931	42,805	5,157	66	172	6,773	£535	464	45	325	46	228
Torfaen	96,682	48,081	5,170	-	203	9,559	£1,003	728	59	301	61	312

* Total capacity / number of attendances calculated from sustainability matrix for sessions required per head of population. Based on consultations with GP / NERs only and not of encounters in primary care.
** MSK capacity / number of attendances based on 12% of total estimated capacity
^ Prescribing costs estimated from
\+ Referral patterns identified from referrals received into specialities from GP – medical on WPAS

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Appendix 4

ABUHB comparative measures (for AB provided services)

4.A Analysis of the utilisation of available services across each borough is set out below:

	BG	Torfaen	Newport	Caerphilly	Mon	Gwent
Population Served	71,491	96,682	158,931	187,155	101,468	615,727
GP: Total Annual Consultations MSK Consultations	334,830 46,876	416,515 58,312	680,311 95,244	797,770 111,688	375,206 52,529	2,604,63 2 364,648
GP MSK drugs prescribed: Units £k Rates per 10kpopn Rates per head	64,591 394k 9,035 £5.50	92,421 567k 9,559 £5.86	107,648 670k 6,773 £4.21	147,188 961k 7,864 £5.13	80,246 490k 7,900 £4.83	492,094 3,082k
PC Based Physio: DAC Attends Wte Cost of wte Cost per Attend FCP Attends Wte Cost of wte Cost per ave	1,821 0.8 1,777 0.50	1,958 1.00 0	2,735 2.00 1,052 0.53	0 0 8,707 3.50	0 0 0	6,514 3.8wte £180.7k £27.75 11,536 4.53wte £254k £22.02
	NCN Funded					
PC referrals to : Physiotherapy Orthopaedics, Podiatry, Rheumatology, Diagnostic scans	1,101 2,792 364 460 4,814	2,913 3,018 571 592 7,304	5,196 3,629 715 735 7,381	6,858 4,502 973 951 8,225	5,692 2,942 479 565 6,749	21,730 16,883 3,102 3,303 34,203
Mainstream Physio : Self-referrals Referrals from PC T&O/Rheum/ED Demand(- ROTTs) DNA rates Attendances New Attendances FUP Wte: WTE £: **Cost per ave Attend**	1,378 1,101 2,235 4,171 8.6% 3,812 14.15wte £586k	1,060 2,913 2,522 5,083 8.5% 4,650 17.24wte £714k	1,478 5,196 4,720 9,850 10.1% 8,855 33.41wte £1.383m	54 6,858 4,909 9,065 7.3% 8,403 30.75wte £1.273	48 5,692 2,978 7,075 5.1% 6,714 24wte £993k	4,018 21,730 17,364 35,244 32,435 74,045 119.6wte £4.949m £46.47
MSKI Physio: Demand - PC Demand – other ROTTS/DNAs New Attendance FU Attendance Wte: Wte £: Cost per ave attendance	173 0.33wte £13k	1,105 2.10 wte £83k	1,114 2.12wte £84k	1,314 2.5wte 99k	679 1.29wte £51k	4,385 1,775 (3,100) @ 53% 2,800 2,405 8.35wte £329k £63.20

	Max wait = 14 weeks; ROTT reasons include – treatment no longer needed/ already on T&O waiting list/ appropriate for mainstream physio.					
Podiatry (Referrals to)	364	571	715	973	479	3,102
Rheumatology: Referrals ROTTs/DNAs etc Attendances – New Attendances - Fup	 460 41% 271 1,291	 592 43% 337 1,640	 735 35% 475 2,520	 951 39% 576 3,549	 565 41% 332 1,458	 3,303 40% 1,991 10,458
Orthopaedic: PC referrals ROTTs OP attendances Treatments Conversion to treat rate	 2,792 25% 2,030 OP 791 Treats 39%	 3,018 26% 2,610 OP 1,047 Treats 40%	 3,629 27% 3,556 OP 1,467 Treats 41%	 4,502 23% 3,920 OP 1,774 Treats 45%	 2,942 29% 2,432 OP 906 Treats 37%	 16,883 14,548 OP 5,985 Treats 41%

4.B Analysis of Comparative Rates per head of population

	BG	Torfaen	Newport	Caer	Mon
Population	**71,491**	**96,682**	**158,931**	**187,155**	**101,468**
	7.149	9.668	15.893	18.716	10.147
Population % Gwent	**12%**	**16%**	**26%**	**30%**	**16%**
GP managed cases per head	0.66	0.60	0.60	0.60	0.52
Presrcibing (MSK) costs per head	£5.50	£5.86	£4.22	£5.13	£4.83
Pescribing cost as % of total MSK drug spend	13%	18%	22%	31%	16%
Physiotherapy:					
Local service activity per head	0.050	0.020	0.024	0.047	-
Local Physio service - WTE per 10k popn	0.182	0.103	0.159	0.187	-
Local Physio service - Spend per 10k popn	£ 9.23	£ 4.96	£ 7.87	£ 10.47	£ -
PC Referrals to MSKI per head	24.199	114.292	70.093	70.209	66.918
MSKI Attendances as %	3.9%	25.2%	25.4%	30.0%	15.5%
MSKI Physio Spend per 10k popn	£1.82	£8.58	£5.26	£5.27	£5.02
PC Referrals to Mainstream Physio per head	0.013	0.019	0.025	0.030	0.049
PC Referrals to Mainstream as %	5.4%	10.4%	23.4%	32.0%	28.9%
Mainstream Physio spend per 10k popn	£ 8.19	£ 7.38	£ 8.70	£ 6.80	£ 9.79
Self Referrals to Mainstream Physio per head	0.019	0.011	0.009	0.000	0.000
Waiting time for First Physio Appointment	No Wait	No Wait	No Wait	No Wait	14 Weeks for routine
Diagnostics:					
GP diagnostic activity per head	0.075	0.092	0.069	0.067	0.095
% shares of diagnostic scans (GP requested)	11%	19%	23%	27%	20%
Spend per head (GP requested)	£ 1.36	£ 1.66	£ 1.31	£ 1.29	£ 1.73
% share of spend (GP requested)	11%	18%	24%	27%	20%
Orthopaedics :					
GP referrals to Orthopaedics per head	0.039	0.031	0.023	0.024	0.029
GP referrals as % share	16.5%	17.9%	21.5%	26.7%	17.4%
OP activity per head	0.028	0.027	0.022	0.021	0.024
% GP referrals accepted as OP activity	72.5%	86.2%	97.4%	86.5%	82.4%
% OP Activity Proceed to Treatment	27.0%	26.0%	26.0%	30.0%	26.0%
Elective Procedures per 10k popn	111	108	92	95	89
Elective Precedures as a % of total	13%	17%	25%	30%	15%
Cost of Treatments (£k) per head	£0.047	£0.052	£0.044	£0.045	£0.042
% share of total spend	13.3%	17.6%	24.5%	29.6%	15.1%

Products	Lead	T&F Group	Supported by	December				January					February				March				April					May			
				WE 4th	WE 11th	WE 18th	25th	1st	WE 8th	WE 15th	WE 22nd	WE 29th	WE 5th	WE 12th	WE 19th	WE 26th	WE 5th	WE 12th	WE 19th	WE 26th	WE 2nd	WE 9th	WE 16th	WE 23rd	WE 30th	WE 7th	WE 14th	WE 21st	WE 28th
Resource Group																													
Therapy (Physio/podiatry) T&F Group established	SHB	SHB/ GD/EJL																											
Therapy (Physio/podiatry) Pathways established			JD						**Pathways completed**																				
Therapy (Physio/Podiatry) Activity mapped to Pathway Maps			JH							**Activity**																			
Therapy (Physio/Podiatry) Workforce mapped to Pathway Maps			CB								**Workforce**																		
Orthopaedic T&F group established	IJ	IJ/LG/ CB																											
Orthopaedic Pathways established			JD						**Pathways completed**																				
Orthopaedic Activity mapped to Pathway Maps			DB							**Activity**																			
Orthopaedic Workforce mapped to Pathway Maps			CB								**Workforce**																		
Radiology T&F group established	AK	AK/IJ/LG																											
Radiology Pathways established			JD						**Pathways completed**																				
Radiology Activity mapped to Pathway Maps			DB							**Activity**																			
Radiology Workforce mapped to Pathway Maps			CB								**Workforce**																		
Rheumatology T&F group established	MH	MH/LG																											
Rheumatology Pathways established			JD						**Pathways completed**																				
Rheumatology Activity mapped to Pathway Maps			DB							**Activity**																			
Rheumatology Workforce mapped to Pathway Maps			CB								**Workforce**																		
Financials associated with mapped reources	GD	LG/GD	SB/CH/FD								**Financials**																		
Programme Budgeting variation identified across Boroughs	CH	CH/SB	Advisory Group																										
Receive PROM/PREM opportunities for improvement	AC	GR/DM	SB																										
Metrics and KPIs indentified	FD	AC/RH/SM	BD																										
Current MSK measurements and metrics mapped to Pathway Maps, where possible												**Metrics**																	
Identification of opportunities for improvement	RH	FD/AC/SM	DB										**Opps identified**				**Opps identified**												
Bringing together all mapping of resource Pathway Maps	AC		JD									**Ror RH to review**																	
Work through gaps, receive advice, collectively finding an agreeable methodology to map resources	RH	Resource Group												**Final Review by Res Group**	**Report for Service Modellin**			**Final Review by Res Group**	**Report for Service Modellin**										
Report or presentation prepared for Programme Board: Challenges fcaing MSK provision in ABUHB - disparate pathways and inequity of access/ impact of covid 19 on backlog and on waiting times for treatment Current Pathway Maps Current resources mapped to pathways Current metrics & opportunities for improvement Current PROMS & PREMS - what does this signal? Opportunities for improvement ? PB variation and opportunities for improvements identfied for AB What were the challenges/compromises due to lack of data? Summary of opps.	RH	FD/AC														**Report for Programme Board**				**Report for Programme Board**									
Service modelling Group																													
Needs assessment by NCN/ locality	TBA																												
Prevalance incidence by NCN/ locality	TBA																												
Baseline informatics	DB/AL																												
Pathway mapping	As below Resource Group																												
Compare current performance to 'best in class' - to include patient experience and outcomes, equity of access/ Where can improvements be made?/ What targets can be applied?	CK																												
To recommend strategic principles for the new pathway model - as they align to WG recommended guidelines for MSK, and also taking into account limiting factors specific to the AB infrastructure/ framework.	CK																												
To recommend the best evidenced model, as it aligns with AB and WG guiding principles, and also with the AB 'best fit' parameters.	CK																**Therapy model agreed**												
Present pathway modelling options																			**CK to meet with Specialties**										
Expected Benefits and Improvements																							**SMG meeting**		**Report for PB**				
Recommendations for Preferred Pathway model																													
Right sizing for AB																													
Referral directory																													
Referral and acceptance protocols																													
Pathway Map (from referral to OP) returned to Resource Group	SM																												
MSK Website	SM															**Spec**			**Tender**				**Build**				**Implement**		

MSK PATHWAYS @ ANEURIN BEVAN UHB

Version 0.2

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit, Finance & Risk Committee Thursday, 8th April 2021 Agenda Item: 2.2

Aneurin Bevan University Health Board

Update on the Integration of Eye Care Pathways

Executive Summary

This report provides a update to the Audit Committee in relation to the Integrated Eye Care Pathway for Gwent, outlining the following areas:

- Clarity on the opportunities available
- Progress, milestones and targets
- Assessment of engagement with clinicians in taking the programme forward
- Expected outcomes – efficiencies, performance, finance, patient experience
- VBHC Team engagement with clinicians to get the project going

The Committee is asked to: (please tick as appropriate)	
Approve the Report	√
Discuss and Provide Views	√
Receive the Report for Assurance/Compliance	√
Note the Report for Information Only	

Executive Sponsor: Nick Wood, Executive Director of Primary & Community Care, Mental Health – Senior Responsible Officer: Melanie Laidler General Manager Primary Care & Community Division

Report Author: Beverley Davies, Interim Eye Care Pathway Lead

Report Received consideration and supported by :

Executive Team		**Committee of the Board [Public Partnerships & Wellbeing Committee]**	

Date of the Report: 26th March 2021

Supplementary Papers Attached:
Appendices 1, 2, 3 and 4

Purpose of the Report

The Senior Responsible Officer (SR0) for the Integration of Eye Care Pathways was requested to attend the Audit Committee on the 3rd December 2020 to provide an update following the Executives approval to progress with the Proposal for Integration in September 2020.

The Audit Committee requested that the SRO return in April 2021 to provide an update on progress as outlined below:

- Clarity on the opportunities available
- Progress, milestones and targets
- Assessment of engagement with clinicians in taking the programme forward
- Expected outcomes – efficiencies, performance, finance, patient experience
- VBHC Team engagement with clinicians to get the project going

Background and Context

2. Introduction

2.1 Integration provides the ability to build services on evidenced based clinical and management models and frameworks across the whole life course and system. Adopting this approach will enable clear plans and learning to support the development of future whole system patient journey integrated for chronic disease pathways, such as Diabetes, Hypertension etc.

2.2 The following sets out the proposed Vision, Key Priorities and Key Themes, as reflected in the (Together for Health: Eye Care Delivery Plan 2013-18) for the Integration of Eye Care Health in Gwent.

2.2.1 Vision and Key Priorities

Our vision is to develop high quality, patient focused, integrated services to improve the eye health of people living in Gwent, so they can benefit from better sight throughout their life. For those who develop sight impairment, we want to ensure they receive appropriate care, support and rehabilitation.

2.2.2 Key Priorities are:

- Preventing avoidable sight loss and improving eye health
- Early identification of poor eye health and sight problems
- Providing high quality, efficient, accessible services
- Ensuring integration of services and patient focussed delivery
- Providing care and support for people living with sight/dual sensory impairment

2.2.3 Key Themes

The Integration of Eye Health Care in Gwent (Together for Health: Eye Care Health Delivery Plan 2013-2018) has 3 key themes of action, these include:

- Raising awareness of eye health and the need for regular sight tests
- Early detection of eye health and sight problems – targeted for people at risk
- Providing access to high quality, integrated services and support for
  - Primary and Community Services
  - Specialist Hospital Services
  - People with sight/dual sensory impairment

2.3 What Opportunities Does Integration Offer

2.3.1 Integration offers the opportunity to deliver a truly Clinical Futures Whole System model of patient-centred pathways spanning life cycles and organisational boundaries. Pathways costed, evidenced based, transparently monitored and evaluated with the patient at the centre.

2.3.2 All the major literature worldwide, political, clinical and planning at a both National and Regional level all support and advocate for the integration of eye care services to meet the current demand/harm and mitigate the increased projections of eye disease over the next 10 years unless action is taken.

Therefore Integration enables the Health Board and partners within Gwent to achieve best practice for the provision of Eye Care. It should be noted that although the World Health Organisation, key Clinical Bodies such as the Clinical Council for Eye Health Commissioning and The Royal College of Ophthalmologists and College of Optometrists and Welsh Government endorse integrated pathways for Eye Care research has not identified where this has been achieved to date to the extent that this proposal is suggesting. Therefore, the Health Board will be a trail blazer in the delivery of a true whole system eye care integrated pathway across the life course in Gwent.

The Integrated Eye Care Service will comprise of the following Key Elements & Principles:

Key Elements:-

- A Single Whole system Integrated Eye Care Pathway;
- Shared Clinical Leadership across Professions i.e. Ophthalmology, Orthoptist, Optometry and Nursing;
- Ring fenced Budgets and resources, value for money;
- Have accountability for all Eye Care services including prevention and treatment with an emphasis on 'Home to Home' integrated Patient Pathways of Care;
- Integrated Care Pathways for all major Disease Areas such as, Glaucoma, Wet AMD etc. following NICE Guidance;
- Optimisation of Prudent Healthcare Principles;
- Shared and Agreed Vision on Priorities and Resources across private and statutory provisions, enhancing and promoting fluid systems for delivery and prevention.

Key Principle:-

"Patients managed in the most appropriate service according to risk stratification of the conditions and skills of the practitioner across the whole system", to enable:

- Delivering Better Outcomes;
- Maintaining Quality and Safety;
- Maximising the use of all capacity and reducing variation;
- Improving Access and Choice;
- Aligning Capacity to Need.

2.4 Outcomes and Benefits of Whole System Integration for Patients and Staff

Patient satisfaction and experience is essential in relation to our services, however it is also fundamental to have high quality staff and professionals who are utilised to their full potential and happy in their work and care they provide.

Through Whole system integration we can enhance and improve the releasing of the following benefits with enhanced integrated clinical leadership and governance:

- Improved effective outcomes;
- More appropriate and effective patient management and pathways;
- Increased patient safety and reduction in harm;
- Ability to instigate a mechanism for clinical audit across the whole system;
- Improved competence of the workforce and work satisfaction;

- High levels of patient experience and ability to monitor and gain whole system view;
- Appropriate infrastructure (equipment, premises etc.) to maximise the benefits from resources to deliver increased patient care
- Pooled budget to reduce duplication of effort, maximise and direct resources appropriate to meet patient demand and deliver safe and effective equitable services across Gwent;
- Having a more consistent approach to eye care pathways will lead to earlier detection of eye problems, and quicker access to appropriate services and treatments which are so important to achieve better outcomes for patients;
- Improved staff satisfaction through peer support, supervision, leadership and the ability to be involved in the whole system pathways increasing understanding, innovation and evolution.

2.5 Organisational Benefits of Integration

The Nuffield Trust (2011) identified the follow key benefits of Integration of Eye Care Services, as follows:

- Improved access and choice
- Services delivered consistently across Gwent and integrated with the rest of the pathways;
- Less duplication and waste (fewer inappropriate and low quality referrals, and more patients with relatively low risk conditions managed in Primary Care);
- Sign up to work to nationally or locally agreed protocols collaboratively;
- Better data to inform commissioning and delivery plans;
- The ability to work more closely with GPs and provision for GPs to refer patients into the Integrated Eye Health Care Service for further local assessment;
- Redirecting work from Ophthalmology Service that can safely and effectively be managed in the Primary Care Services;
- Transparent financial control and allocation.
- Adherence and delivery on National Drivers for Integration

Appendix 1 provides a more detailed map of the current challenges with service delivery and the benefits of integration.

This will be adapted as the programme for integration progresses to provide further detail which will include key indicators and outcome measures through the development of a performance dash board.

3. Progress, milestones and targets

3.1 It should be noted that there has been limited progress of Integration during the period between December and March. This primarily been due to the delay in securing a funding source for the appointment of the Senior Lead Manager.

3.2 The funding has now been sourced on a temporary basis via the Primary Care & Community Transformation Funding stream. This is a time limited funding stream, therefore, during the first year of integration a more permanent funding arrangement will need to be sourced.

3.3 Funding was identified at the beginning of March and with negotiation with the Clinical Futures Team, an interim arrangement was made for the secondment of a

Senior Programme Manager to take up a post whilst the process of advertising and appointment for the permanent role took place.

3.4 During this period a detailed map of current financial arrangements has been undertaken. This is at a high level at this time, however, identifying where funding sits across the organisation will enable a good baseline assessment to be carried out to determine its use and risks should funding be used for other core service delivery. Below provides further detail in relation to the work carried out so far.

3.5 In addition, there a number key focused actions that need to happen to enable a safe and efficient approach to integration. The key actions are detailed within the Plan (Appendix 2).

3.6 It is important to note that integration is the beginning of the process for a whole system patient pathway, the objectives and actions proposed within the High Level Delivery Plan provides a robust and evidenced based platform upon which services and pathways can be designed, delivered, monitored and evaluated to ensure future sustainable services based on best practice encompassing prevention, treatment, care and support for patients.

3.7 Integration will enable active management principles to design pathways and integration structures that are fit for purpose, future proofed and cost effective. Whilst driving commissioning of services through service improvement principles based on need, demand, best practice, value for money and value based healthcare outcomes.

4. Assessment of engagement with clinicians in taking the programme forward

4.1 Senior Clinical engagement with this proposal has been embedded from the start. The proposal has been driven positively by senior clinicians from the following professions:

- Consultant Ophthalmologists
- National Optometry Lead
- Local Optometry NCN Lead
- Senior Orthoptists
- Senior Lead Nurses

Appendix 3 and 4 provides more details in relation to all individuals involved in this proposal.

4.2 A number of meetings and engagement events have developed and shaped the proposal for integration. There was a strong indication that pace was needed to deliver on this to enable services to transform and support the national agendas in integration, training of Optometrists, review of ODTCs and outsourcing contracting to deliver value based health care principles and value for money.

The table below provides a timeline of meetings and forums where this proposal has been discussed.

Date	Forum/Meeting	Attendees
16.05.2019	Meeting - Executive Leads, Scheduled Care Management & Clinical Futures	Nick Wood, Claire Birchall, Glenys Mansfield, Leanne Watkins, Melanie Laidler, Julie Poole, Bev Davies
19.06.2019	Workshop – Clinical Leads and Management Leads from Scheduled Care, Primary Care & Community, NCN	Full list of invitees (Appendix 3)
24.06.2019	Meeting - Clinical Futures Delivery Board	Usual Attendees
29.07.2019	Meeting – Executive Leads for Primary Care, Community & Mental Health & Operational Delivery	Nick Wood, Claire Birchall, Julie Poole, Melanie Laidler, Bev Davies
25.10.2019	Workshop – Clinical Leads & Stakeholders	Full list of invitees (Appendix 4)
16.12.2019	Executive Leads Meeting – Paper	Usual Attendees
16.03.2020	Executive Leads Meeting – Presentation	Paper didn't go due to COVID pressures
07.09.2020	Executives Lead Meeting – Presentation	Usual Attendees
08.09.2020	Integrated Eye Care Collaborative	Usual Attendees multi-agency meeting
03.12.2020	ABUHB Audit Committee	Usual Attendees (Melanie Laidler presented)
15.12.202	Integrated Eye Care Collaborative	Usual Attendees multi-agency meeting

5. Expected Outcomes of Integration

The following section provides some examples of expected outcomes of integration in relation to:

- Patient Experience
- Efficiencies
- Performance
- Finance

It should be noted that as the programme progresses these outcomes will be refined during 2021/2022. However the delivery of these outcomes will not be achieved during this period as business as usual will be sustained as the Integrated Pathways are developed with a view to implementation in April 2022.

5.1 Patient Experience:

- More people have regular sight tests
- More information on reducing the risk of developing eye disease, including self-help and services expected to be available
- More people become aware of the importance of eye health
- Reduced inequalities in access to optometry services
- More people in residential care having regular sight tests
- More children in special schools having sight tests in school
- More children having their vision screened on school entry
- People with sight impairment receive care and support which addresses all their needs – both physical and emotional
- People with sight impairment are offered specialist training that enables them to be independent and get out and about

5.2 Efficiencies:

- More optometry practices providing the full range of extended eye care services in the community – Prudent Healthcare Principles
- More people are aware of the most appropriate point to access eye care services, if they have an eye problem that needs urgent attention
- More people at high risk of eye disease accessing eye care services in the community including people with diabetes, people with a family history of glaucoma and people from ethnic minority groups
- People are seen within the primary and community setting, where it is clinically appropriate
- Joined up local eye care, hospital eye care and support services

5.3 Performance:

- People receive appropriate access to on-going care and management of their eye condition
- Service users and carers are involved in the design of services and people's views on services are sought regularly and acted on to ensure continuous improvement
- People are satisfied with the care they receive at their local optometry practice
- People are satisfied with the care they receive when they visit the hospital eye services
- People are satisfied with the care they receive when from social services
- Metrics provided by national datasets, audits, surveys and service improvements. For example, data on sight tests paid for by the NHS, is derived from the ophthalmic service payment process administered by NHS Wales Shared Services. The Welsh Health Survey has questions about eye-sight difficulty and the public's use of optometrists
- Reduction in RTT
- Reduction in ED attendances
- Reduction in GP attendances
- Increase in Hospital Eye Specialist services capacity to see appropriate patients

5.4 Finances:

The Finance Team identified that planned budgets for eye problems/injuries were spread across a number of Divisions. This provides many challenges to financial consolidation and planning and integration will have the following benefits:

- Transparency of Planned Eye Care Budgets across the Organisation;
- Ability to direct financial resources to the appropriate team;
- Reduction in effort and duplication;
- Providing improved financial assurance and management;

Some initial work was undertaken between Primary Care & Community Services and Scheduled Care Business Partner Accountants in 2019 to map spend across Eye Care pathways. A high-level review of current funding has been undertaken and is detailed in the table below.

Meetings have been set up with the relevant AFDs / BPAs to commence a more detailed analysis of the current funding and expenditure to map and produce costed integrated pathways for Eye Care.

Options will also be explored in relation to how funding can best be planned and allocated to support the integration i.e. Virtual budgets, pooling etc.

	2020/21			2019/20		
Eye Care Service	**Budget £**	**Forecast Spend £**	**(Surplus) / Deficit £**	**Budget £**	**Actual Expenditure £**	**(Surplus) / Deficit £**
PRIMARY CARE						
EHEW	£1,508,381	£1,982,274	**£473,893**	£1,508,381	£1,995,149	**£486,768**
Low vision	£102,393	£152,777	**£50,384**	£102,393	£150,261	**£47,868**
ODTC	£487	£312,707	**£312,220**	£0	£333,549	**£333,549**
WET AMD	£0	£186,123	**£186,123**	£0	£169,691	**£169,691**
PRIMARY CARE TOTAL	**£1,611,261**	**£2,633,880**	**£1,022,619**	**£1,610,774**	**£2,648,650**	**£1,037,876**
SECONDARY CARE						
Scheduled Care	£13,734,141	£12,210,801	**-£1,523,340**	£12,585,017	£13,149,550	**£564,533**
External Commissioning	£2,918,629	£2,528,133	**-£390,496**	£3,599,666	£3,597,789	**-£1,877**
SECONDARY CARE TOTAL	**£16,652,770**	**£14,738,934**	**-£1,913,836**	**£16,184,683**	**£16,747,339**	**£562,656**
A.B.U.H.B. TOTAL	**£18,264,031**	**£17,372,814**	**-£891,217**	**£17,795,457**	**£19,395,989**	**£1,600,532**

- An initial budget of approximately £18.3m has been identified across the Health Board
- This excludes Primary Care drugs (£1.5m) and Optometry Services which is Non Cash Limited (£6.4m)
- £1m of the External Commissioning budget is non-recurrent
- Work has commenced to review which elements of the budget are fixed and which are potentially releasable

It has been agreed that the Senior Lead Manager will be funded from the Transformation Fund Programme in 2021/22 to enable the work on the Eye Care Pathway to commence. A recurrent funding source will need to be identified from 1st April 2022, as the Transformation Funding comes to an end on the 31st March 2022.

6. How are the VBHC Team engaging with clinicians to get the project going?

The Value Based Health Care Team will be a critical member of the programme and will be engaged at the outset of this process. Due to the delays in the appointment of the Senior Lead Manager, work has been delayed although initial conversations have occurred and a project support manager has been identified along with a senior VBHC Clinical lead.

Recommendation
The Audit Committee is asked to note the update provided on the Integration of Eye Care Pathways as requested on the 3rd December 2021 and to receive regular updates from the SRO.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	There are several risks associated with the delivery of the current service. The most immediate is the need to fully undertake capacity and demand modelling for both the Glaucoma and Wet AMD ODTC's. The current contracts have been extended numerous times and a full procurement for services will need to be undertaken during early 2021. Risks linked to Risk Register and meeting demand, not delivering RTT and FU Outpatient Plans. Potential harm to patients, future demand increases. Linkages to prevention agenda, inability to undertake transformation in with pace. No overall strategy for eye care services. Risk in relation to funding for the Senior Pathway Lead as funding only agreed for 2021/22. Need to identify appropriate permanent budget from 2022/23.
Financial Assessment, including Value for Money	The proposal will establish a budget for the entire integrated pathway. There are several unfunded pathways within the service delivery an integrated approach to service delivery will provide an opportunity to establish core funding and pull together funding from across the whole system. Reduce avoidable duplication. The approach with the integrated eye care service is to follow the prudent principles for patient care, particularly embedding the value agenda.
Quality, Safety and Patient Experience Assessment	➢ Increase patient satisfaction ➢ Decrease delays ➢ Mitigate risk to any harm to patients ➢ Care Closer to harm ➢ Meet waiting times
Equality and Diversity Impact Assessment (including child impact assessment)	Not undertaken to date, but will be completed during the programme delivery.
Link to Integrated Medium Term Plan/Corporate Objectives	This plan fully aligns to the IMTP Process and has been included within the 20/21 plans.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term** – One of the principle aims is the ability to produce and implement an Eye Care Service Strategy that is sustainable and has both medium and long term solutions **Integration** – This is the overall aim of this proposal **Involvement** – There has been a multi-disciplinary approach to the development of this proposal from Primary, Community and secondary care. Representation for CHC and RNIB via the Eye Care Pathway Group.

	Collaboration – Workshops have been held with the key stakeholders as outlined above. **Prevention** – The integration proposal ensures that pathway working will be reviewed right from the prevention agenda to secondary care. The aim being to reduce/eliminate the risks outlined within the current service models and implement more sustainable services to meet both present and future demands.
Glossary of New Terms	
Public Interest	Publishable. Interested parties will include the RNIB, Community Health Council, WG

Challenges & Benefits of integration Eye Care Services in ABUHB				
Challenges		Benefits		
Organisational	Patients	Patients	Organisational	Leadership & Governance
Divisions working in isolation – leading to duplication of effort and lack of transparency	High number of patients on follow-up waiting lists – not being seen in timely manner resulting in potential harm	Reduced barriers between primary care, community services and hospital	Improved access and choice	Improved and effective outcomes
Unclear Demand & Capacity - Lack of integrated Patient Pathways to support assessment	RTT pressures means that patients who require follow up are being delayed to ensure that First Contact patients are seen within timescales	Personalised and coordinated health services to meet patient's needs	Consistent delivery and access to services across Gwent	More appropriate and effective patient management and integrated patient pathways
Number of Groups managing the same group of patients	Potential Harm – Patients on follow-ups have a diagnosis and therefore at risk of losing sight while waiting for appointments	Increases the ability to provide proper planning, cross-referral, signposting and inter-professional communications	Reduction in duplication and waste	Whole system approach to allocation of resources – better resource management and transparency
No clear overarching Plan	Skilled workforce currently not being deployed according to patient need	Shared and standardised information, clear and accessible messages with systemised approaches across the whole system	Redirection from secondary care services to primary care	Seamless patient pathways planning and delivering on Prudent Healthcare Principles
Funding Streams and Flows		Opportunity to use Optometry Services as a point of contact for Public Health messages, training for staff to deliver MEC	Improved working with primary care and prevention services	Seamless patient pathways planning and delivering on Prudent Healthcare Principles
Increasing demographic demand	Delayed diagnosis and treatment potential for harm	Opportunities to simplify information for population to ensure they access the right service at point of need – not A&E or GPs	Opportunity to maximise benefits from EPR and other technological solutions across the whole system – improved shared care resulting in increased quality of care	Single Vision for Eye Care services underpinned by share patient records supporting shared care
Delivery Unit – 12	Improving	Follow-up	Maximises	Enables full

recommendations	outcomes for patients	appointments at time of need	opportunity to secure funding with an integrated system	delivery of recommendations across the whole system of prevention through to care/treatment
High waiting lists	Delay in treatment and potential harm	Improved experience for patients with integrated patient pathways	Ability to influence new role developments to support training and education i.e. nurse injectors	Patients being seen by the right professional at time of need
High demand versus high risk i.e. cataract versus AMD, chronic conditions	Potential for harm as systems not aligned to support patient journeys	Improved experience for patients with integrated patient pathways	Aligning resources correctly to prevent harm and improve patient outcomes	Ability to prioritise and make decisions based on evidence or demand and risk assessments
Commissioning: • Funding for OTDC finish in March 2021 • WetAMD – Medical Retina • Glaucoma • Referral Refinement	Equity and access to service	Improved equity, access and quality of services	Better use of resources. Robust Commissioning, Contracting and management in place. Health Board designing the pathways and commissioning intelligently against demand and population needs	Transparency and clear plans and commissioning cycles in place to ensure best value for money and patient outcomes
Budgets over several Divisions, Family & Therapies, Scheduled Care & Primary Care & Community. No clear transparency of resources or expenditure. No Division owning the commissioning process. Budgets no longer available.		Better use of resources and ability to provide more prevention services and care closer to home	Transparency of budgets and accountability to ensure robust financial management and forecasting against agreed programme plans for service transformation	Clear Governance around resources, staffing, financial and commissioning to enable transformational patient pathways across the whole system
Overspend in Scheduled Care – Outsourcing, RTT, Follow-up out-patient appointments	Increased waiting times, potential harm	Reduced harm, increased access and choice	Organisation meeting RTT, financial balance, patients seen when they should and by the right person	Accountability and Responsibility across the system to improve patient outcomes and organisational objectives
Outsourcing – £2m spent on outsourcing – Management of contract and control	Patients Experience – delayed appointments, care not being provided close to home (outsourcing & OTDCs),	Ability to provide patients with improved equitable access to services	Quality data collection and analysis – for demand/capacity and commissioning of services and outsourcing	Robust Contracting, Commissioning and monitoring based on organisational drivers, population needs to maximise

	delays in treatment are not clear where patients should access their eye health care (not GPs, Optometrists etc.)		Health Board in control of what needs to be commissioned and where	resources and quality of care
Prudent Use of Medication: Increasing costs of medication		Better use of medication and medicine management	Best use of resources, medication, review and potential for diversion of costs to support prevention	Whole system oversight with transparency and better control

Appendix 2: High-Level Programme Plan for Integration

Proposed High-Level Programme for Integration of Eye Care Service 2020/2021		Preparing for Integration					Initiating Integration					
Themes		**2021/22**					**2022/23**					
Resources	**Key Actions**	**Mar-Apr**	**May-Jun**	**Jul-Aug**	**Sept-Oct**	**Nov-Dec**	**Jan-Feb**	**Mar-Apr**	**May-Jun**	**Jul-Aug**	**Sept-Oct**	**Nov-Dec**
Senior Manager	Post Appointed											
Business Continuity	**Key Actions**	**Mar-Apr**	**May-Jun**	**Jul-Aug**	**Sept-Oct**	**Nov-Dec**	**Jan-Feb**	**Mar-Apr**	**May-Jun**	**Jul-Aug**	**Sept-Oct**	**Nov-Dec**
Primary Care	No change to Service continuity during 2021/22											
Community Care	No change to Service continuity during 2021/22											
Secondary Care	No change to Service continuity during 2021/22											
Tiertary Care	No change to Service continuity during 2021/22											
Programme Initiation and Strategy	**Key Actions**	**Mar-Apr**	**May-Jun**	**Jul-Aug**	**Sept-Oct**	**Nov-Dec**	**Jan-Feb**	**Mar-Apr**	**May-Jun**	**Jul-Aug**	**Sept-Oct**	**Nov-Dec**
Programme Structure, Developing a Strategy with work programme, Baseline Assessment, Benchmarking, Benefits Realisation, Patient Pathways	Research Best Practice principles in Integration											
	Identify all budgets for eye care across the system											
	Develop Option Apprasial for Budget Management											
	Assess current workforce and skill mix resources across whole system											
	Scope principles for integration and implications around workforce & OD											
	Develop Communication & Engagement Strategy											
	Develop clear Governance structures for integration and delivery											
	Engage with key stakeholders											
	Activity Shift - current and future											
	High level resources assessment - current costs - variable, semi, fixed											
	High level resources assessment - future cost - releasable and transfer offset											
	Assess Demand Growth estimates - current and future											
	Patient Pathways - map current and identify new proposed pathways											
	Review current Service Levels Agreement and initiate commissioning processes											
	Training plans developed and commissioned - upskilling Optometrists in the community											
	Review current outsourcing contracts and make recommendations for future Service Level Agreements											
	Develop a single Vision for Eye Care Services with Strategy, Implementation Plan with Delivery Timescales											
	Benefits analysis and release											
Governance Framework	**Key Actions**	**Mar-Apr**	**May-Jun**	**Jul-Aug**	**Sept-Oct**	**Nov-Dec**	**Jan-Feb**	**Mar-Apr**	**May-Jun**	**Jul-Aug**	**Sept-Oct**	**Nov-Dec**
Key Objectives to develop and implement	Governance Structure											
	Memorandum of Understanding											
	Terms of Reference for each Work stream											
	Eye Care Board											
	Clinical Expert Panel											
	Patient/Carer Panel											
	Commissioning Panel											
	Reporting Framework for work programme to the Eye Care Board/Executive Lead/Regional Groups											
Implementation Integration	**Key Actions**	**Mar-Apr**	**May-Jun**	**Jul-Aug**	**Sept-Oct**	**Nov-Dec**	**Jan-Feb**	**Mar-Apr**	**May-Jun**	**Jul-Aug**	**Sept-Oct**	**Nov-Dec**
Implementing full Integration of Eye Care Services across the system - shifting of resources	Structure for governance developed and agreed											
	Reporting and management structures implemented											
	Consultation processes implemented (if required)											
	Continuous service delivery across Ophthalmological/Optometry/Orthoptics Services both Secondary and Primary Care											
	Budgets under one Management Structure											
	Resources under one management system											
	Accountability of service sustainability, transformation and integration agreed under one Executive Lead and Governance Structure (whole system)											
	Patient pathways developed, mapped and costed											
Benefits Realisation & Evaluation	**Key Actions**	**Mar-Apr**	**May-Jun**	**Jul-Aug**	**Sept-Oct**	**Nov-Dec**	**Jan-Feb**	**Mar-Apr**	**May-Jun**	**Jul-Aug**	**Sept-Oct**	**Nov-Dec**
Performance & Measuring system changes	Align across the system performance measurements and systems to create a single integrated Dash Board											
RTT	Continuous management and monitoring of RTT to seek improvements											
Targets	Continuous management and monitoring of Targets to seek improvements											
Patient satisfaction	Develop and implement Patient Surveys											
PROMS & PREMS	Whole system PROMS & PREMS											
Staff satisfaction	Engagement, communication, feedback and surveys											
Better management of Resources	Benchmarking and forecasting for Financial release, increased satisfaction of staff, alignment of staff to right intervention, reduction in outsourcing, increase in primary care and prevention											
Build regular review and evaluation of change	PDSA - embedded regular systems for review/evaluations and learning to ensure best practice, best use of resources and improved outcomes for patients											
Commissioning & Procurement	**Key Actions**	**Mar-Apr**	**May-Jun**	**Jul-Aug**	**Sept-Oct**	**Nov-Dec**	**Jan-Feb**	**Mar-Apr**	**May-Jun**	**Jul-Aug**	**Sept-Oct**	**Nov-Dec**
WetAMD (Medical Retina)	Contract Reviews, Specifications developed, Tendering with Procurement undertaken, Award of Contract and Implementation											
Glaucoma	Contract Reviews, Specifications developed, Tendering with Procurement undertaken, Award of Contract and Implementation											
Retina	Contract Reviews, Specifications developed, Tendering with Procurement undertaken, Award of Contract and Implementation											
Referral Refinement	Contract Reviews, Specifications developed, Tendering with Procurement undertaken, Award of Contract and Implementation											
Cataracts	Contract Reviews, Specifications developed, Tendering with Procurement undertaken, Award of Contract and Implementation											

Appendix 3: List of Invitees to Workshop 19.06.2019

Nick Wood – Executive Director Primary Care, Community & Mental Health
Christopher Blyth – Consultant Ophthalmologist & CD
Mike George – Optometry Advisor – Primary Care Unit Welsh Government
Stephanie Campbell – Optometrist and NCN Lead for Optometrists
Nicola Turner – Head of Orthoptics
Andy Bagwell – Consultant Anaesthetics
Linda Jones – Lead Nurse
Julie Poole – Interim General Manager
Glenys Mansfield – General Manager Scheduled Care
Jayne Roberts – Directorate Manager for Ophthalmology
Samantha Bright- Primary Care Contracts Manager
Sally ONeil – BPA Scheduled Care
Alex Thomas - BPA Scheduled Care
Leanne Watkins – Clinical Futures Programme Director
Melanie Laidler – Deputy Director Primary Care, Community & Mental Health
Liam Taylor – Medical Director Primary Care
Sian Millar – Divisional Director Primary & Community Care
Victoria Taylor – Head of Primary Care
Jodie Collins – Senior Primary Care Manager
Chris Commins – BPA Primary Care & Community
Sian Jenkins – BPA Primary Care & Community
Tracy Morgan – General Manager Primary & Community Care
Rachel Prangley – Senior Primary Care Manager

Appendix 4: List of Invitees to Workshop 25.10.2019

Nick Wood – Executive Director Primary Care, Community & Mental Health
Christopher Blyth – Consultant Ophthalmologist & CD
Mike George – Optometry Advisor – Primary Care Unit Welsh Government
Stephanie Campbell – Optometrist and NCN Lead for Optometrists
Nicola Turner – Head of Orthoptics
Alison Hoskins – Head of Service Blaenau Gwent Local Authority (representing the other 4 Local Authorities)
Nik Sheen – Clinical Lead for EHEW - Cardiff University
Rebecca John – Clinical Lead for Low Vision - Cardiff University
Rhodri Griffiths – AM Welsh Government
Sharon Beckett – SightCymru
Shiraz Megji – Optometrist Independent Contractor
Sian Biddyr - The Royal National Institute of Blind People (RNIB)
Claire Birchall – Executive Director of Operations
Suzanne Jones – Head of Strategic Finance & Innovation
Rebecca Bartlett – Clinical Lead Low Vision Cardiff University
Melanie John – Service Development Manager Primary Care & Community
Elin Edwards - The Royal National Institute of Blind People (RNIB)
Clare Reece-Archer – Project Manager Welsh Government
Craig Mackenzie – Independent Optometrist Contactor
Dawn Saville – Member of the Collaborative Eye Care Group
Huw Davies – Hospital Optometrist
Jemma McHale – CHC Deputy Chief Officer
Julia Osmond – Public Health Wales
Lloyd Bishop – Assistant Director of Performance
Patricia Cory – Patient Representative
Julie Poole – Interim General Manager
Jayne Roberts – Directorate Manager for Ophthalmology
Leanne Watkins – Clinical Futures Programme Director
Melanie Laidler – Deputy Director Primary Care, Community & Mental Health
Liam Taylor – Medical Director Primary Care
Sian Millar – Divisional Director Primary & Community Care
Victoria Taylor – Head of Primary Care
Jodie Collins – Senior Primary Care Manager
Chris Commins – BPA Primary Care & Community
Tracy Morgan – General Manager Primary & Community Care
Rachel Prangley – Senior Primary Care Manager

Audit Committee
Integrated Eye Care Pathway

Name- Melanie Laidler, Chris Commins, Beverley Davies
08.04.2021

What were we asked to do?

On the 3rd December 2020 The Audit Committee requested that the SRO return in April 2021 to provide an update on progress as outlined below:

- Clarity on the opportunities available
- Progress, milestones and targets
- Assessment of engagement with clinicians in taking the programme forward
- Expected outcomes – efficiencies, performance, finance, patient experience
- How are the VBHC Team engaging with clinicians to get the project going?

Opportunities for Integration of Eye Care Health in Gwent

Integration provides a number of opportunities, as follows:

- To deliver a truly Clinical Futures Whole System model of patient-centred integrated pathways spanning life course and organisational boundaries. Pathways costed, evidenced based, transparently monitored and evaluated with the patient at the centre
- Ability to build integrated pathways on evidenced based clinical and management models/frameworks across the life course and whole system;
- Transparency of pathways will enable the shift of care from Secondary Care services to community and primary care – delivering on Prudent Health Care Principles, Care Closer to Home, Future Generations Act, Health & Social Care White Paper, reducing harm, improving on patient safety and experience

What Opportunities Does Integration Offer for Patients & Staff

Through Whole system integration we can enhance and improve the releasing of the following benefits with enhanced integrated clinical leadership and governance, as follows:

- Improved Effective outcomes;
- More appropriate and effective patient management and pathways;
- Increased Patient safety and reduction in harm;
- Ability to have mechanism for Clinical audit across the whole system;
- Improved competence of the workforce and work satisfaction;
- High levels of patient experience and ability to monitor and gain whole system view;
- Appropriate infrastructure (equipment, premises etc.) to maximise the benefits from resources to deliver increased patient care
- Transparent budgets to reduce duplication of effort, maximise and direct resources appropriate to meet patient demand and deliver safe and effective equitable services across Gwent;
- Having a more consistent approach to eye care pathways will lead to earlier detection of eye problems, and quicker access to appropriate services and treatment which are so important to achieve better outcomes for patients;
- Improved staff satisfaction through peer support, supervision, leadership and the ability to be involved in the whole system pathways increasing understanding, innovation and evolution

What Opportunities Does Integration Offer the Health Board

- Improved access and choice
- Services delivered consistently across Gwent and integrated with the rest of the pathways;
- Less duplication and waste (fewer inappropriate and low quality referrals, and more patients with relatively low risk conditions managed in Primary Care);
- Sign up to work to nationally or locally agreed protocols collaboratively;
- Better data to inform commissioning and delivery plans;
- The ability to work more closely with GPs and provision for GPs to refer patients into the Integrated Eye Health Care Service for further local assessment;
- Redirecting work from Ophthalmology Service that can safely and effectively be managed in the Primary Care Services;
- Transparent financial control and allocation.
- Adherence and delivery on National Drivers for Integration

Progress, Milestones and Targets

- Limited progress due to ability to secure funding for Senior Pathway Lead;
- Interim secondment commenced 15th February 2021;
- Post will be appointed to during April 2021;
- Funding secured for 2021/22 from Transformation Funding Scheme;
- During 2021/22 need to secure permanent funding stream for post;
- Financial baseline assessments on current budgets across Divisions commenced;
- Discussions with Public Health Wales Team and Value Based Health Team in relation to involvement/participation in programme commenced;

Assessment of engagement with clinicians in taking the programme forward

Senior Clinical engagement with this proposal has been embedded from the commencement of this discussion. The proposal has been driven positively by senior clinicians from the following professions:

- Consultant Ophthalmologists
- National Optometry Lead
- Local Optometry NCN Lead
- Senior Orthoptists
- Senior Lead Nurses
- Integrated Eye Care Collaborative Board

Expected Outcomes of Integration

The Audit Committee asked what would be the expected outcomes in the following areas:

- Patient Experience
- Efficiencies
- Performance
- Finance

It should be noted that as the programme progresses that these outcomes will be refined and added to over 2021/2022. However the delivery of these outcomes will not be achieved during this period as business as usual will be sustained as the Integrated Pathways are developed with a view to implementation in April 2022.

Patient Experience

- More people have regular sight tests
- More information on reducing the risk of developing eye disease, what people can do for themselves and what services to expect to be available
- More people aware of the importance of eye health
- Reduced inequalities in access to optometry services
- More people in residential care having regular sight tests
- More children in special schools having sight tests in school
- More children having their vision screened on school entry
- People with sight impairment receive care and support which addresses all their needs – both physical and emotional
- People with sight impairment are offered specialist training that enables them to be independent and get out and about

Efficiencies

- More optometry practices providing the full range of extended eye care services in the community – Prudent Healthcare Principles
- More people are aware of the most appropriate point to access eye care services, if they have an eye problem that needs urgent attention
- More people at high risk of eye disease accessing eye care services in the community including people with diabetes, people with a family history of glaucoma and people from ethnic minority groups
- People are seen within the primary and community setting, where it is clinically appropriate
- Local eye care, Hospital eye care and support services are all joined up

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Performance

- People receive appropriate access to on-going care and management of their eye condition
- Service users and carers are involved in the design of services and people's views on services, are sought regularly and acted on to ensure continuous improvement
- People are satisfied with the care they receive at their local optometry practice
- People are satisfied with the care they receive when they visit the hospital eye services
- People are satisfied with the care they receive when from social services
- This will be measured by national datasets, audits, surveys and service improvements. For example, data on sight tests paid for by the NHS, is derived from the ophthalmic service payment process administered by NHS Wales Shared Services. The Welsh Health Survey has questions about eye-sight difficulty and the public's use of optometrists
- Reduction in RTT
- Reduction in ED attendances
- Reduction in GP attendances
- Increase in Hospital Eye Specialist services capacity to see appropriate patients

Finances

	2020/21				2019/20		
Eye Care Service	Budget £	Forecast Spend £	(Surplus) / Deficit £		Budget £	Actual Expenditure £	(Surplus) / Deficit £
PRIMARY CARE							
EHEW	£1,508,381	£1,982,274	**£473,893**		£1,508,381	£1,995,149	**£486,768**
Low vision	£102,393	£152,777	**£50,384**		£102,393	£150,261	**£47,868**
ODTC	£487	£312,707	**£312,220**		£0	£333,549	**£333,549**
WET AMD	£0	£186,123	**£186,123**		£0	£169,691	**£169,691**
PRIMARY CARE TOTAL	**£1,611,261**	**£2,633,880**	**£1,022,619**		**£1,610,774**	**£2,648,650**	**£1,037,876**
SECONDARY CARE							
Scheduled Care	£13,734,141	£12,210,801	**-£1,523,340**		£12,585,017	£13,149,550	**£564,533**
External Commissioning	£2,918,629	£2,528,133	**-£390,496**		£3,599,666	£3,597,789	**-£1,877**
SECONDARY CARE TOTAL	**£16,652,770**	**£14,738,934**	**-£1,913,836**		**£16,184,683**	**£16,747,339**	**£562,656**
A.B.U.H.B. TOTAL	**£18,264,031**	**£17,372,814**	**-£891,217**		**£17,795,457**	**£19,395,989**	**£1,600,532**

- An initial budget of approximately £18.3m has been identified across the Health Board
- This excludes Primary Care drugs (£1.5m) and Optometry Services which is Non Cash Limited (£6.4m)
- £1m of the External Commissioning budget is non-recurrent
- Work has commenced to review which elements of the budget are fixed and which are potentially releasable

How are the VBHC Team engaging with clinicians to get the project going?

- Due to the delays in securing Senior Pathway Lead work has been delayed due to the complexity of the task ahead in firstly planning Integrated structures and pathways;
- The Value Based Health Care Team will be a critical member of the programme and will be engaged at the outset of this process;
- There will be a staged approach to Integration and the VBHC team will be a key member in advising and leading the development of PROMS & PREMS during 2022/2023;
- Initial discussions with the VBHC Team has positively confirmed that the following resources will be allocated to support this programme:
  - Senior VBHC Clinical Lead;
  - Project Manager to support VBHC initiatives

Future updates to Audit Committee

- Audit Committee is asked how would they like to receive updates from this programme going forward;
  - Regular attendance on 3 monthly basis, and/or
  - Highlight Reports on 3 monthly basis?

Any Questions?

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GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit, Finance & Risk Committee Thursday 8th April 2021 Agenda Item: 2.3

Aneurin Bevan University Health Board

Progress against the digital strategy

Executive Summary

This report is to provide a high level update on the implementation of the Health Board's Digital Strategy, in particular the progress made over the last 12 months against the four key themes:

Digital community – Enable people to manage their health and care needs independently wherever possible

Digital organisation – Enable staff to be equipped to deliver truly holistic care and high quality services

Digital data, information and intelligence – Getting the maximum we can from our data and information

Digital foundations – Provide fast, highly reliable and secure devices, storage and networks

During 2020 – 2021, the Informatics teams were redeployed and re-prioritised programmes of work due to the increased demand for digital services. Two major episodes of intense and rapid business change were greatly enabled, namely the Health Board's response to COVID-19 and the early opening of the Grange University Hospital. The scale and speed of COVID's impact on the Health Board necessitated the Informatics team to rapidly adapt by ceasing much work in flight, reconfiguring services, and expediting delivery in priority areas.

A more detailed briefing on the progress being made in delivering the Digital Strategy will be provided at a Board Briefing session in May 2021.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	✓

Executive Sponsor: Nicola Prygodzicz

Report Author: Mike Ogonovsky

Report Received consideration and supported by :

Executive Team		**Committee of the Board [Public Partnerships & Wellbeing Committee]**	

Date of the Report: 4th April 2021

Supplementary Papers Attached:

Purpose of the Report
The report provides the Audit Committee with a position statement and a progress update on the digital strategy. In addition to this it was asked if the update could include references to the new WG digital funding.
Background and Context

Health Board Digital Strategy

The Digital Strategy approved by the Board in July 2019 sets out the vision and core themes for digital as a key enabler to the transformation agenda set out in the ambitions of A Healthier Wales and the Local Clinical Futures Strategy.

The themes within the Health Board digital strategy support the Clinical Futures Strategy with its emphasis on optimal service configuration for patient safety and shifting care closer to home. They also underpin the 5 Ministerial priorities of prevention, reducing health inequalities, supporting primary care and mental health and providing timely access to care.

Digital community – Enable people to manage their health and care needs independently wherever possible

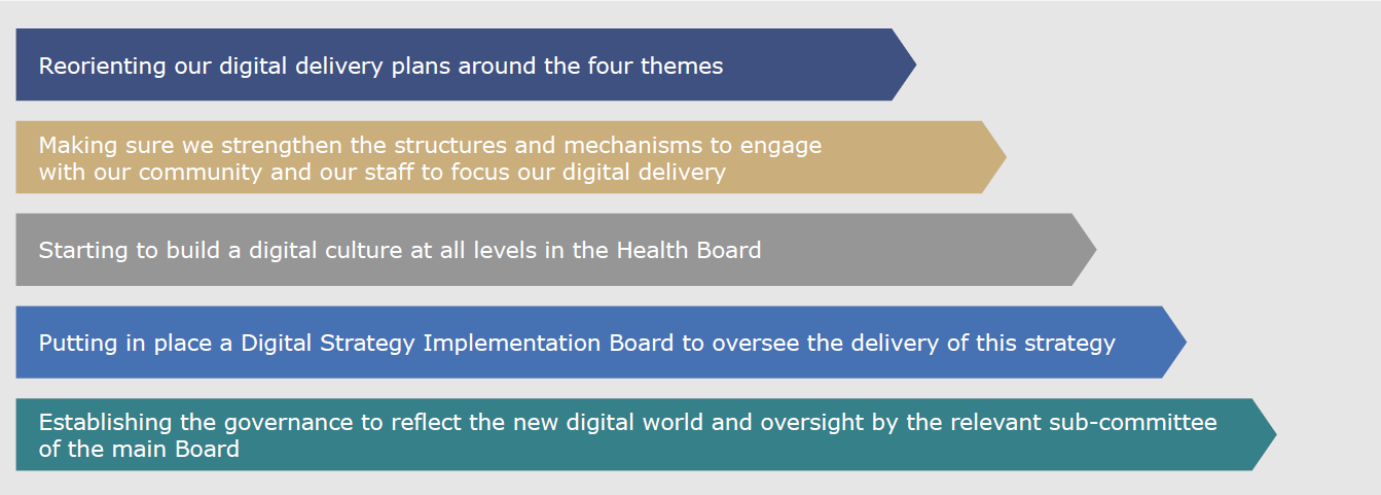
Digital organisation – Enable staff to be equipped to deliver truly holistic care and high quality services

Digital data, information and intelligence – Getting the maximum we can from our data and information

Digital foundations – Provide fast, highly reliable and secure devices, storage and networks

The strategy also set out the high level priorities, principles, implications and next steps in the implementation of the digital strategy over the next five years and beyond.

Next steps



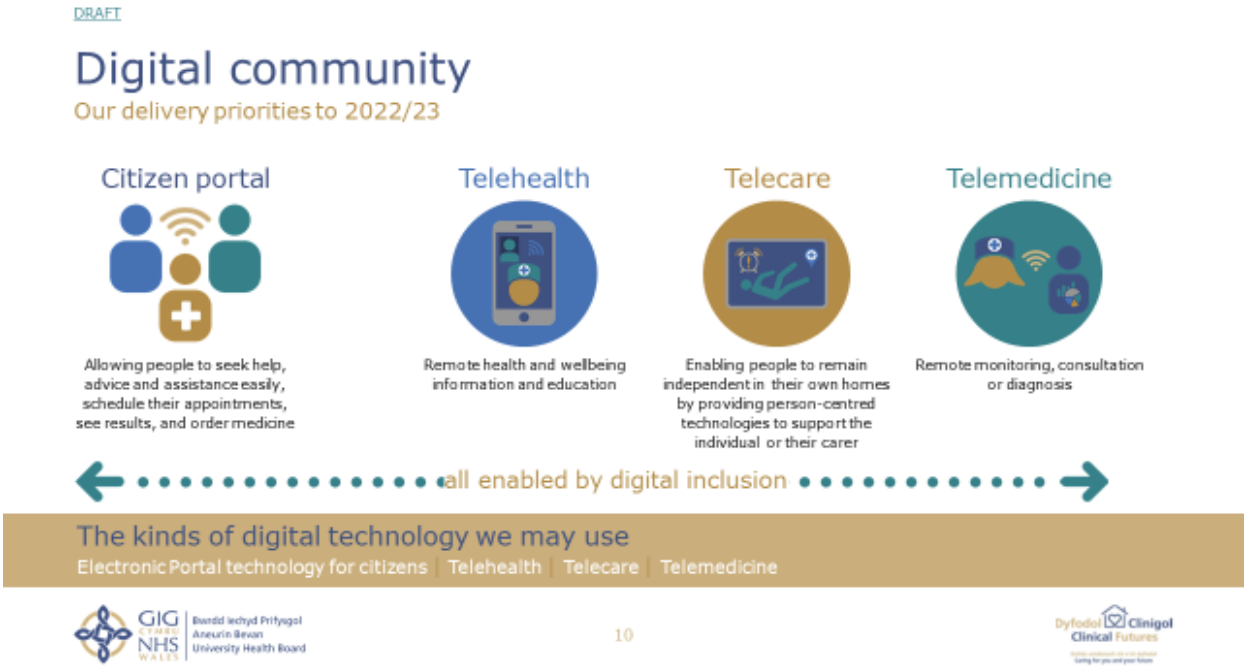
During the second half of 2019/20 good progress was made in progressing with the next steps identified in the strategy as follows:

- Existing delivery plans were reoriented across the four themes
- A high level draft financial assessment of delivering the strategy where possible
- Progress with the recommendations set out in the Channel 3 report through the development of a new target operating framework (TOF) which also involved designing a new team structure to support delivery of the strategy and a new governance structure to oversee the strategy implementation.

In 2020-21 two major episodes of intense and rapid business change, namely the Health Board's response to COVID and the early opening of the Grange University Hospital, were greatly enabled by the use of digital technology. The scale and speed of COVID's impact on the Health Board necessitated the Informatics team to rapidly adapt by pausing or ceasing some of its current work, reconfiguring services, and expediting delivery in priority areas. Whilst this redirected attention away from the development of the TOF and the new structures it resulted in an escalation of elements of the digital strategy.

The following sections focus on the key areas of progress against each of the themes since the strategy was approved and particularly the last twelve months as part of the pandemic response.

Digital community – Enable people to manage their health and care needs independently wherever possible



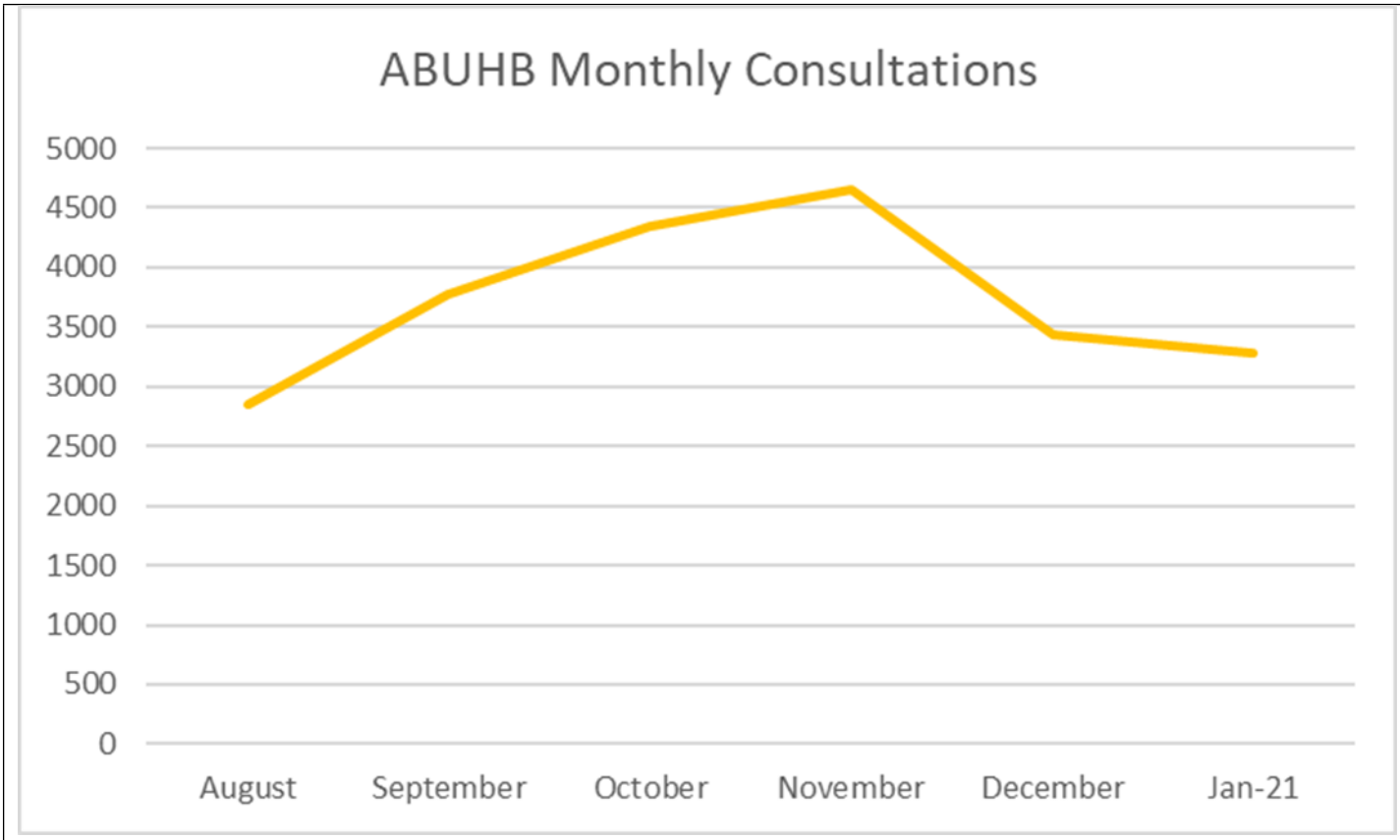
Virtual Consultations – Attend Anywhere

The National TEC Cymru programme, hosted by the Health Board and delivering at a national and local level, enabled video consultation and clinics using the product Attend Anywhere in rapid response to the pandemic. As can be seen in the graphs below, the number of video consultations across NHS Wales, particularly in secondary care has continued to grow. Currently the National Programme is supporting over 5,000 consultations per week.

Within our own Health Board the growth of video consultation has led the usage in comparison to other Health Boards until very recently when the TEC team in ABUHB were temporarily re deployed to support the Mass Vaccination Programme (MVP) leading to a slowing of growth. Since the beginning of the COVID pandemic ABUHB teams have carried out more than 22,000 consultations.

Currently Informatics is agreeing with MVP the release of some staff and backfill for others so that the programme can return to its plan. Furthermore the national business case is now approved protecting continuity and growth of video consultations along with some financial support of Local Health Boards.

The Health Board continues to grow its use of VC with additional specialities and departments scheduled to adopt the approach as the project restarts in Q1. The graph below shows the rate of consultations by month for the Health Board.



Moving forward beyond COVID, continuing virtual outpatient clinics will strongly support the Clinical Futures goal of delivering care closer to home whilst avoiding the costs, time and stresses involved in patients travelling to hospitals.

Mass Vaccination Programme

From August 2020-21, the Health Records department actively planned for and implemented the COVID mass vaccination booking programme for the Health Board. Initial cohorts of around 20,000 frontline clinical staff from primary care, community, 760 WAST staff and 36,000 shielding patients were identified, and all patients were registered and placed on waiting lists in readiness for the immunisation booking with delivery through WPAS in December; followed by a rapid migration to the Welsh Immunisation System when the system became available. As part of emergency planning, a further 2,500 antibody tests for staff were also booked.

The Vaccination programme successfully commenced in December 2020 with the rapid deployment of the Welsh Immunisation System; this required staff training, the operational set-up of 6 vaccine centres including enabling IT connectivity from non NHS sites to access the NHS network and systems. Staff have been redeployed from Health Records to the Mass Vaccination Booking Centre and additional recruitment from agency and Track, Trace and Protect programme and army personnel have also provided support. ABUHB now has control of the issue of letter and this has created a much more stable throughput in terms of telephony.

National effort is now being considered for an online booking platform that will allow patients to make, cancel or rearrange their own appointments and because of its knowledge and experience the Health Board Informatics team has been asked to contribute to the proposal.

As additional vaccination centres were required to be rapidly set up at short notice the Informatics team did an excellent job to meet the challenge and respond in a timely way.

Citizen Platform

The Health Board is committed to the provision of patient facing services, and broader citizen-facing services for well-being and prevention. Working in collaboration with the emerging all-Wales programme supporting Digital Services for Patients and Public, the aim is the delivery of a citizen application that will enable and empower people to access their health service from a 'one stop shop' platform. Early objectives include a service for self-help advice for wellbeing and support of musculo-skeletal issues e.g. back pain that can be safely self-managed. Sponsored by the Planned Care Programme in Welsh Government, ABUHB Informatics is leading a national project in partnership with other Health Boards, Trusts and NWIS to enable the remote care of Urology Prostate patients.

Supporting the Value Programme

Informatics has facilitated an extension of the contract with partners Dr Doctor to provide a text and remind services for Outpatients Appointments and for the collection of Patient Reported Outcome Measures. Much work by the teams in Information, Informatics and Value with the supplier has been undertaken to further utilisation of the platform for individual consultations and to derive better information to the Health Board.

Digital organisation – Enable staff to be equipped to deliver truly holistic care and high quality services

Welsh Community Care Information System

The Welsh Community Care Information System (WCCIS) will be implemented across Mental Health & Learning Disabilities (MH&LD) services following the completion of a national upgrade to the software this year (2021). Following the Phase 1 go LIVE in

MH&LD, proposed to go LIVE in the Autumn of 2021, the aim is to commence rollout to Community Nursing.

Readiness activities have continued across Phases 1 to 3, including distribution of 90% of iPads allocation to MH&LD staff and over 70% of devices rolled out to Community Nursing; development of national MH&LD assessment forms; data migration testing from ePEX; data cleansing of existing duplicate records; Community Nursing form development and the commencement of baseline benefits measurements.

The Health Board also hosts the Regional WCCIS team which provides support to the Local Authorities in Gwent currently using WCCIS. This team continues to focus on data quality, to ensure the system is "clean" for the on-boarding of ABUHB data; development of a security model to allow person level information to be shared across Gwent; continued development and standardisation of Gwent wide forms and reports and to ensure that a regional approach to testing, configuration and change management is adopted.

The WAO report on WCCIS published in October 2020 recognised the implementation of WCCIS and realisation of benefits is complex and ambitious. It also recognises that the national rollout is taking much longer and proving more costly than expected. The report acknowledges that the expected functionality, due to be delivered by the supplier, has been significantly delayed and consequently delayed implementations across Wales, including the implementation in ABUHB.

During 2020, an audit of the ABUHB programme was carried out by NHS Wales Shared Service Partnership (NWSSP) to assess the adequacy and effectiveness of internal controls and concluded that substantial assurance can be given highlighting that an appropriate risk management process is operating for the local WCCIS programme; that issues that may impact on the delivery of WCCIS functionality are appropriately managed and that appropriate supplier management processes are in place to enable value for money.

Remote Collaboration - MS Teams

Informatics rapidly procured, built and delivered over 1,700 laptops to staff enabling them to work safely from home. This increased the ICT client equipment estate and with this came increased and different demands on the ICT teams to provide remote support.

In addition to sourcing and setting up the necessary hardware, the Health Board expedited the rollout of MS Teams to all staff as a tool for collaboration, communication and virtual meeting. This delivery benefited from the recruitment of Office 365 specialist staff within ICT, a comprehensive training programme, and the assistance of the many Digital Champions across all divisions.

MS Teams is now our standard tool for collaboration. It is supporting COVID safe working and has demonstrated enduring benefits in reducing the time and cost of travel whilst releasing hours back to the services. This experience of using collaborative tools is being fed into the wider Agile Working programme being run by Workforce and Organisational Development to secure a range of lasting benefits from new ways of working.

Robotic Process Automation

With the increased volume of patient admissions and need for increased COVID reporting, especially in relation to bed management, the introduction of robotic process automation was trialled. Robotic Process Automation (RPA) is a form of automated business process that uses software to emulate repetitive tasks that humans would normally perform. The automated tasks are carried out in a standardised way, reducing error, and can operate 24/7. RPA was identified as beneficial in addressing the combined impact of increased demand with potential reduction in staff due to sickness, shielding or social distancing limits on site. The initial service to be automated was the manual transcription of hospital admissions, transfers and discharges (ATD) from the Clinical Work Station application to the Welsh Patient Administration System. After RPA implementation, the majority of this work, circa 6,000 transactions per week, were automated and processed 24x7; this eliminated the time lag of 2-3 days between the systems. This improved reporting for the Information team with up to date information and reports on bed status to support timely operational data analysis and information to the Executive Team and to Welsh Government was extremely important during high levels of Covid. The Health Records staff released from the manual tasks were made available to support the Mass Vaccination programme.

Following this success, a further 26 scenarios have been identified for automation with potential cost and time savings estimated. In the event of successfully automating all of these, the Health Board could benefit from releasing approximately 38 members of staff from routine and repetitive activities to work on more value added or patient focused activity. As the services start to understand the benefits of RPA more scenarios are surfacing. A business case is being produced for funding of an RPA service on an ongoing basis to deliver the automations and related savings.

RPA Benefits Case Dashboard

Number of processes reviewed	26
Number of process selected for RPA	26
Estimated Annual Cost	£450,840
Target Timescale	13 mths
Expected FTE Benefit	37.9
Gross Annual Savings	£946,869
Net Annual Benefit	£496,029

The Grange University Hospital Early Opening

In response to the pandemic, the Health Board opened the Grange University Hospital. As a result, the Informatics department collectively turned its attention and resource to deliver all the ICT infrastructure and software systems required and ensure staff were trained in time for opening in November 2020. This included:

- over 1,400 staff were trained on Vocera communication badges providing hands free communication and workflow to find the next available colleague
- over 1,400 staff were trained on the CareFlow electronic patient flow system,
- 80+ Clinical applications were updated & tested,
- Pathology system (LIMS) was successfully upgraded,

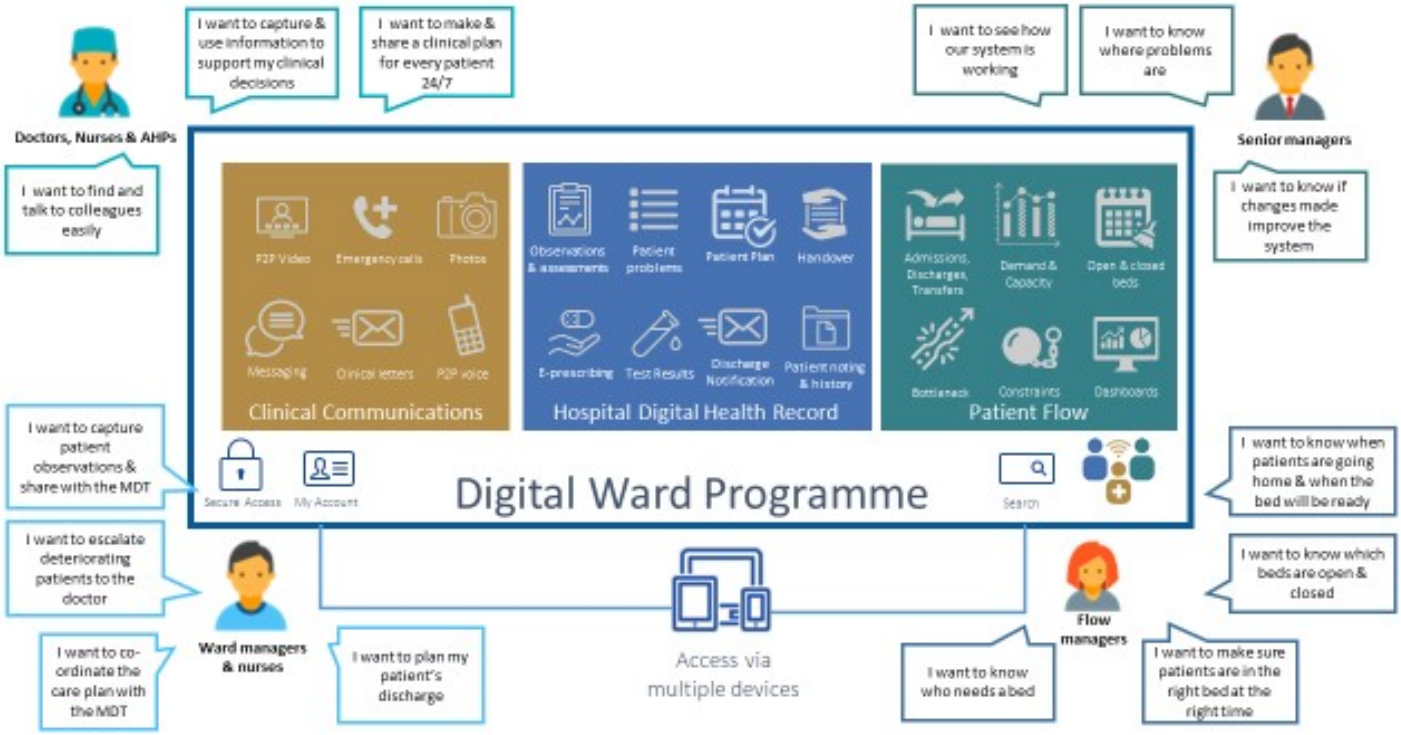
- Increased usage of electronic test requesting by GPs and within hospitals making ABUHB the leading Health Board with the highest level of tests requested electronically.
- Providing Digital dictation, especially in hot desking areas
- Implementation of the theatres ICT system and equipment
- Deployment of the A&E Symphony system to a new hospital
- Deployment readiness of clinical applications on devices in GUH
- Post go live support for ward moves in the eLGHs

Digital Ward

The establishment of the Digital Ward programme will enable staff to capture and curate the information they need to support clinical and operational decisions for patients (in-patient and out-patient) in the hospital environment. By offering a number of services and digital solutions focused on hospital staff the Digital Ward Programme intends to:

- Set out the quality standards for the clinical and operational use of applications in a digital ward space, including safety and reliability criteria
- Deliver secure joined-up digital services and information that hospital staff need and want
- Present a coherent user experience through the use of digital devices and applications
- Provide a means to connect services, information, communication channels and systems
- Enable a foundation for exploiting digital solutions and patient information to deliver our services

An overview of the anticipated scope of the Programme is provided below:



A Digital Ward environment is complex and not easily encapsulated to the ward alone because of the nature of workflow across departments supporting the patient care

pathway. A set of workshops were undertaken with key clinical and operational leaders in 2020 to review the patient pathway and identify a set of capabilities required in order to scope and define the Programme.

The Careflow project remains a priority of the Digital Ward programme and the preparation, training and go live of "Careflow" ahead of the opening of the Grange University Hospital was seen as a patient safety imperative. To that end the Programme agreed a "Minimum viable Product" that provided electronic observations and SEPSIS decision support but also a live view of the major hospitals bed state.

Following the delivery of the Minimum viable product (MVP) the programme is now entering benefits realisation and clinical/business change phase. Led by the Medical Director, Director of Operations and Director of Nursing, the change programme will provide a clinically led "Improving Patient Care" programme supported by the digital ward programme. The programme seeks to enhance clinical care, clinician experience and deliver operational efficiencies through the digital enabling programme. Work has commenced on developing best practice models and analysis on the current processes.

The Digital Ward Programme also has a wider portfolio of projects that need to make sense to and be driven by our doctors, nurses and therapists. Taking this approach pushes the complexity to the directorate but crucially means that the portfolio of products align and make care easier, safer and more efficient for the busy ward areas. Three tranches have been identified:

1. Inpatient/ Outpatient Digital Health Record - The Health Board's strategy for the digitisation of Health Records operates within the context of Clinical Workstation (CWS). Most recent focus has been on the scanning of paper records of inpatient episodes of care and outpatient appointments. This has been highly successful with over 436,000 records now digitised and the project being determined as a business as usual operation. Having achieved this the next phase is the development of a digital health record at the point of contact with the patient allowing the direct entry of data to the record without paper, thus, removing the scanning processes. At present there are three areas of work that are being managed:

    a. The CareFlow project – the adoption of CareFlow Vitals that delivers the benefit of a shared digital record of critical bedside documentation including vital signs, Sepsis 6 and fluid management. There are three small pilots in place looking at the use of CareFlow Connect to support clinical task management and handover in ICU and its associated Outreach and Pain teams, Vascular Services and Care of the Elderly at YYF.

    b. Welsh Nursing Care Record (WNCR) adoption – an all NHS Wales project; the Health Board will be able to manage delivery to our wards when appropriate technical issues are resolved to allow WNCR to be made available within CWS.

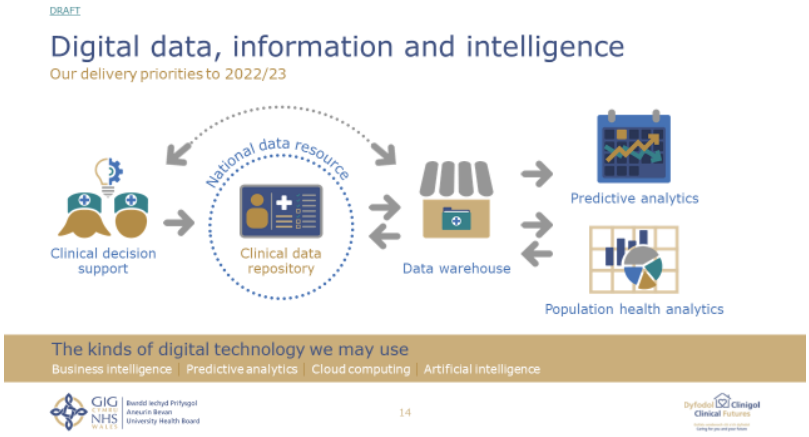
    c. E-forms – the delivery of e-forms is the spine of the digital health record in CWS. The Health Board has an identified list of target forms which is dependent on the development and delivery of the Health Board's Digital Platform and a digital data capture tool that will enable the proliferation of e-

forms to replace paper with the key opportunity of having structured data capture and curation

2. Patient Flow Management - VitalFlo is the bed management system that utilises data input from CareFlow to deliver an accurate bed state with additional core patient discharge status data to be added. All wards have patient data in VitalFlo.

3. Clinical communications - The Health Board has three formal clinical communication tools in place: its core telephony network with two switchboards at RGH & NHH, its pager system and Vocera, a voice activated communication badge which is now in use at GUH, YYF, YAB, RGH & NHH. The Health Board also supports the use of mobile telephony across all sites. The current focus is the implementation, including server upgrade and robust service management arrangements and business change for Vocera at GUH for peer to peer contact, messaging and potentially emergency calling.

Digital data, information and intelligence – Getting the maximum we can from our data and information



ABUHB continues to invest in the development of information and enterprise architecture to ensure we have the critical foundations to enable the collection and re-use of structured clinical data. This will not only support requirements from ABUHB clinical services but also facilitate cross-Health Board information flows supporting patient journeys of care, in collaboration with the National Data Repository.

ABUHB and NWIS have been carrying out joint planning activities to deliver the initial 3 integration priorities of enabling visibility of the GP record, test results and patient care documents within the ABUHB digital platform. This work will also enable ease of sharing information between Health Boards in the South East Region.

A key enabler for delivering a new "Always On" approach with a greater focus on System Planning, Operating, Covid Re-Planning and balancing Demand with Capacity, are the business intelligence tools the Health Board uses.

QLIK is an end to end business analytics platform that enables the Health Board to use data with intuitive visual discovery for business intelligence about service performance. It was implemented 3 years ago and continues to be developed and over the last year there has been significant work undertaken to support the services both in a reporting functionality and operational capacity.

QLIK Apps have been developed with additional functionality to provide reports via email to individuals; these contain main KPI and data charts relevant to the subject. This functionality has been well received and allows instant key measures to be monitored with the QLIK App being available to allow further drill down if required. COVID19, TTP & Vaccination data are good examples of the use of this functionality with daily reports generated whilst the Apps have served as an Operational tool adding value to users.

A QLIK App based on Floor Plans for each ABUHB Secondary/Community Hospital has also been developed; this provides timely information displaying Occupied Beds with measures such as Average Length of Stay together with the patient COVID19 Status, DTOCs, Complex List status etc. This has been well received and is currently being used as an Operational Tool.

Other Apps available and being used to support services are:

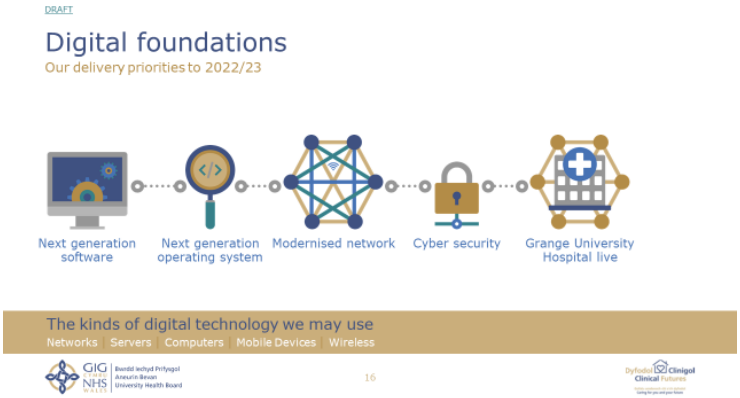
- Cancer
- ED – Reporting & Live
- Mental Health
- Radiology
- Outpatient Transformation,
- Planned Care – WL, Pathways
- Urgent Care
- Discharge Planning
- Primary Care – Out of Hours
- Quality & Patient Safety

Building on the performance and reporting capabilities in Qlik, the Health Board is able:-

- to understand system behaviours in order to improve services,
- review and revise pathways
  and
- project forward using the Lightfoot Signals From Noise (SFN) platform.

SFN will be used to implement a dynamic approach to understanding our current position and identifying opportunities during a time of high variability and uncertainty, enabling us to plan for sustainable change and connect services into clear end-to-end pathways.

Digital foundations – Provide fast, highly reliable and secure devices, storage and networks



Whilst a significant proportion of Digital Foundations projects were reprioritised for 2021-22 to enable Informatics to respond to COVID-19, some activity could not be deferred due to the risks involved. Opening the Grange University Hospital (GUH) in line with the accelerated schedule is an enormous achievement by Informatics and one of which we are very proud. The volume and complexity of the infrastructure elements required was very challenging and included:

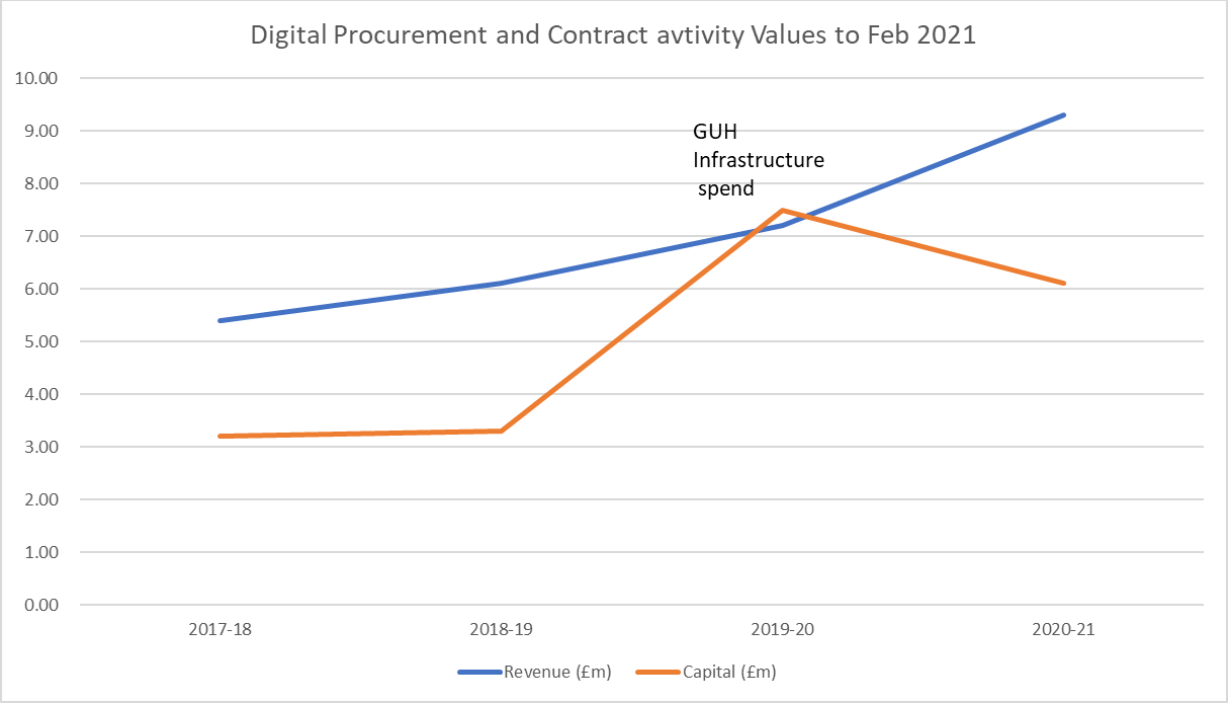
- The deployment of over 1200+ Desktop PCs and Monitors.
- Over 600 phones installed.
- Creating 27 comms rooms with over 12,000 data ports enabled.
- Installing the latest technology to provide a robust and reliable network.
- 300+ Wifi Access Points installed.
- Deployment of mobile telephony masts, UHF Radio and Stanley Bleeps.
- Upgrade to the WPAS infrastructure to improve resilience.
- Implementation of Pathology applications and analyser ICT requirements.
- Pervasive zebra printer deployment for Pharmacy and Pathology services.
- Implementing the national pharmacy system Wellsky including links to pharmacy vending machines, robots and specialist printing. ABUHB was the first to adopt in NHS Wales and the system was then rapidly rolled out to the other hospital sites.
- Implementing new patient monitoring hardware (Mindray) in the Critical Care departments.
- ICT support for the install of a new endoscopy stack system with related integration requirements.
- Pre and post ICT go live support.

GUH has increased the Health Boards overall network footprint by 50% and if viewed through a digital lens, it is as large as the Royal Gwent and Nevill Hall Hospitals combined. This is a successful implementation built on the latest technology and the hard work has provided a state-of-the-art facility for Health Board clinicians and patients.

GUH has the first Software Defined and Secure network in NHS Wales which is the start of an organisational transformation towards the Modernised Network. This enables greater control over who and what can access the network and restricts unauthorised access from unknown devices, enhancing our cyber security and giving Informatics greater confidence that it is able to protect sensitive patient data at a key site.

A range of critical data centre projects took place during COVID-19, including a refresh of both the storage and computer platforms that run all the "local" clinical and non-clinical systems for the Health Board. We continue to lead in Wales in the removal of legacy operating systems on both Server and Desktop, with over 99% of desktops computers now on the latest operating system, Windows 10.

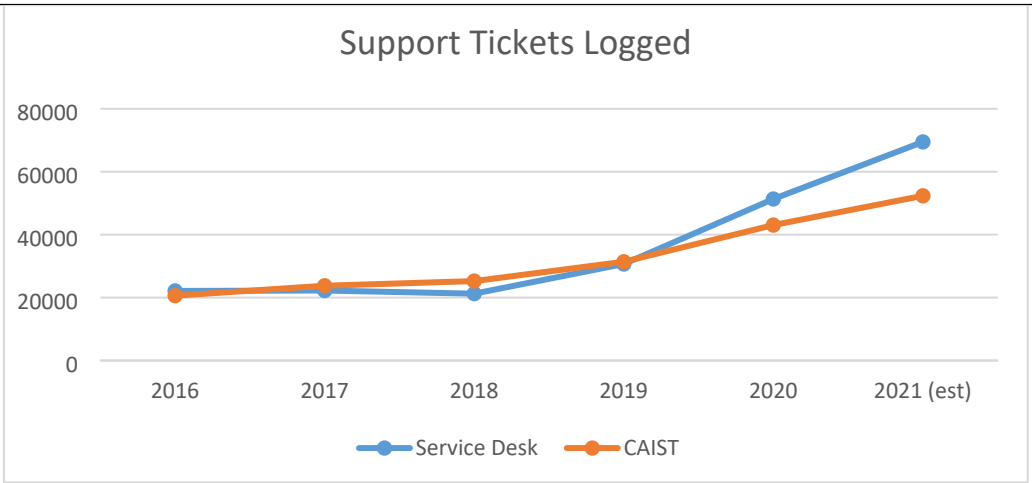
The rapid growth in the dependency on digital services has created challenges for all of our teams. The chart below represents organisational spend on digital and demonstrates a significant increase. The Capital spend in 2019/20 shows the exceptional capital outlay to provision the infrastructure for network and telephony at the Grange University Hospital. It is clear that although the pandemic has meant an increase in spend it continues to rise and has not returned to pre-pandemic rates.



Value of transactions spend on digital per £m

Of course as a consequence of mobilising and digitally enabling the clinical workforce the need to provide support has also increased. Over the last five years we have seen calls to the ICT helpdesk increase from around 65k to over 115k per annum (170% increase in logged "tickets") as people adapt to the new ways of working. This rapid change in dependency has led to long delays to answering calls and an increase in the number of lost calls. We are currently reviewing the ways of working to understand potential adaptations to meet levels of demand before adding further resource.

For example, a recent national change to the password complexity rules has generated a higher than normal volume of calls during the first three months of 2021, however following its implementation, the number of password reset calls should reduce.



Significant resilience work is in progress with the Clinical Work Station (CWS) to ensure that its performance, availability and disaster recovery procedures reflect current best practice and provide a resilient service to clinical staff who depend on it for patient care. This work will include supporting modern browsers, further enhancing the security and functionality of the portal. Improved facilities for digital clinical data capture will be developed, enabling many smaller scale requests from clinical services to be fulfilled without the need for procuring externally sourced systems.

Clinical Application Support

During the period January 2020 to January 2021, the Informatics Clinical Applications Service Desk experienced an average of 20% increase in calls but a 32% increase in calls during the COVID-19 peak. During this period the Clinical Applications Support Team also trained 20% more staff on clinical systems such as WPAS, CWS and ePEX which is a 55% increase from 2019.

The increase in calls and training requirements directly relate to the COVID-19 pandemic, with the increase in recruitment of clinical staff requiring access and training on clinical applications, a national NADEX password policy change and an upgrade of the WPAS environment. It also reflects the support requirement following the implementation of Digital Dictation across new services in the Health Board and the continued support to the Health Boards priority Mass Vaccination Programme (MVP).

Digital Governance & Assurance

Responding to the rapid change in demands over the last year has led to a diversion from what was initially planned. We have also learned lessons from the focus and timely achievement of delivery that was achieved when Informatics pared down its work to the essentials required to meet the challenges of COVID and GUH.

As we enter 2021 with a portfolio backlog and new requests still coming in, it will be essential to plan and prioritise the workload with a strengthened governance framework. To that end the recent recruitment of a Chief Nursing Information Officer to advise and assure the clinical safety and need of digital services has strengthened the Clinical Leadership within Informatics. Over the coming year the aim is to establish the role of the Chief Clinical Information Officer with stronger clinical governance in the form of a Clinical Council to strengthen clinical-digital engagement and assist with prioritisation.

In addition, Informatics will implement a Programme Management Office following the P3O best practice methodology, to keep track of project progress and the pipeline of work.

The Information Governance Unit will continue to provide support to the services and provide assurance to the Senior Information Risk Owner (SIRO) in their role in ensuring that identified information security risks and incidents are managed and that appropriate assurance mechanisms exist. During the COVID-19 pandemic the Information Governance Unit has supported the Test Trace Protect strategy and in particular the Mass Vaccination Programme, ensuring appropriate data sharing processes, privacy notices and data protection impact assessments were in place and this will continue whilst the pandemic persists. Work also continues at a national level to develop and adopt All Wales IG policies and the Data Protection Officer will be engaging to drive forward IG matters in Wales.

Target Operation Framework

Following the adoption of the strategy the Health Board commissioned a review of the capability of both the operating framework within which the Informatics Directorate operates and also the Directorate itself. The report delivered a number of observations and resultant recommendations in the context of the Health Board being able to realise the ambitions set out in the strategy. The report findings recognised the progress being made and showed that:

- There is a committed and skilled workforce.
- There is an IMTP for Informatics and Information that is comprehensive in its scope and provides clarity as to the priorities for the Health Board, strong planning and control for the major delivery programmes (Flow, WCCIS etc.)
- There is strong leadership capability at the senior levels of the Digital Service and strong representation at Executive Board and main Board level by the Executive Lead for Digital.
- Clinical engagement in Digital is strong with both medical and nursing representation within the team.

It also highlighted a number of areas for improvement to achieve the digital ambition set out in our strategy. These were:

At Health Board level:

- There needs to be better alignment of plans for the Health Board, its Change Ambition and Digital.
- Mechanisms for governance and prioritisation of Health Board Digital requirements need to be clearer, more transparent and comprehensive.
- Arrangements between the Digital Service and Divisions are not yet sufficient to enable the Health Board to gain a good understanding of the benefits and possibilities of Digital so that priorities can be clearer and delivery better managed.

At Informatics level:

- Oversight of all delivery is not yet sufficiently holistic and does not yet benefit from having more detailed end to end plans and controls for everything in the IMTP.
- The management layer has too high a span of control at senior team level to be effective.
- There is limited Business Partnering or prioritisation and co-design with Divisions.

Strategically both Welsh Government and Aneurin Bevan University Health Board acknowledge the ever increasing importance of Digital and Information Services and place great importance in ensuring that the governance, processes and establishment is right. The report set out further specific recommendations

Over the long term this means a change in approach but also a recognition of the need to increase investment in the following areas:-

- Augment the core services and processes relating to the wider Health Board with respect to:
  - Business Relationship Management
  - Demand Management
  - Sourcing and Lifecycle Management

- Augment the governance with regards to
  - Digital design to ensure a coherent digital landscape in line with the Digital Strategy.
  - Digital investment with a separate body aligning to PIP and existing business planning processes, as a way of managing the digital investment decisions as a single pipeline on behalf of PIP and the Executive Board.
  - Digital delivery by creating a single Programme Management Office with oversight of the delivery of all approved investment.
  - Digital oversight with a board level subcommittee to periodically oversee all digital delivery and investment. A role often taken by the Finance and Performance Committee in equivalent organisations.

- Adjust the structure of the Informatics Directorate
  - Introduce a new function – Strategy, planning and design - to address the majority of the planning and engagement issues identified in the review.
  - A consolidated delivery function focused on programme and project delivery
  - Creation of Programme Management Office with oversight of all delivery including ICT project delivery.

- A consolidation of service functions with a focus on developing end to end service along best practice guideline, starting with service strategy and service design.
- Expansion of the Office of the Chief Clinical Information Office to address clinical safety of digital solutions
- Creation of an objective business assurance function to improve the quality of digital services.

Following the recommendations identified in the Digital Operating Model Review Report (July 2019) a series of workshops were held with the Heads of Services to identify how best to maximise strengths and address the shortcomings in the organisation.

The workshops took a process and delivery driven approach that would strengthen engagement with the services to better align with service needs according to the priorities within the Health Board as a whole.

The diagram below demonstrates the approach. There are 3 main process areas which logically flow from:

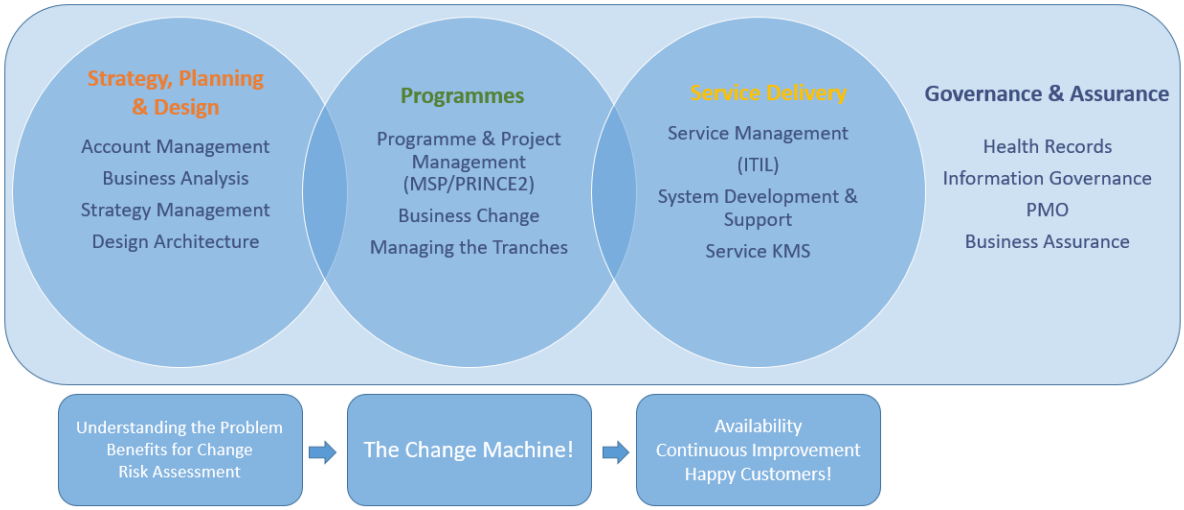
- developing the strategy based on service needs,
- delivering programmes of change based on the priorities of the Health Board
- providing resilient and available services and a good user experience.

Inputting into and supporting each of these process areas are assurance functions such as:

- the Office of the Clinical Informatics Officer providing clinical safety assurance of digital services

and

- Business Assurance providing expertise in health records standards, information governance, testing the quality of services, project management office and directorate & financial management.



The initial phase of restructure has commenced with the interim appointment of the Chief Digital Officer, Chief Technology Officer (Service Delivery) and Assistant Directors for Strategy Planning and Design, Programmes and Governance & Assurance. The aim is to have a digital strategy implementation board from Q1. The target operating framework, structures and proposal is being finalised and will be taken following Executive scrutiny through the Organisational Change Process. It is hoped that by the

autumn the Health Board will be in a position to implement the new overarching governance, structures and new ways of working that will better support the digital journey of the organisation.

Welsh Government Digital Funding

With the announcement of additional funding from Welsh Government for digital health, the following areas are where the Health Board hopes to benefit:

Digital services for patients and the public

- Video consultation
- Technology enabled care – refreshed for 21/22

Digital services for professionals

- Medicines management and e-Prescribing
- Diagnostic services
- Intensive Care (critical care)
- Enhancements to the Welsh Patient Administration System
- Eye care digital system
- Careflow

Data & Intelligent information

- National Data Resource
- Analytics & dashboards

Modernising devices & moving to Cloud services

- Infrastructure modernisation

Guidance from Welsh Government has indicated that Once for Wales programmes will take priority and that organisational priorities outside of this are unlikely to achieve funding although where potential for spread and scale are identified it would be seen more favourably.

Summary

The global pandemic has amplified the potential of digital services in health and has seen huge leaps forward, through necessity, in adoption of new practices. Despite this clearly creating delays in some areas the achievements against strategy where objectives aligned with COVID priorities has been impressive and well received. The next year will see changes to make digital services in the Health Board more accountable, transparent and sensitive to clinical priorities and more focussed on user need. Of course this requires changes in how we prioritise, manage and deliver portfolios of services as a whole organisation going forward.

Recommendation
The Audit committee is asked to note and discuss the progress made across the four themes of the digital strategy and the key priority areas as we move into 2021/22 building on the progress made during 2020/2021 and continue to support the implementation of the Digital Strategy.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The coordination and reporting of organisational risks are a key element of the Health Board's overall assurance framework.
Financial Assessment, including Value for Money	Regular budget reviews are undertaken in conjunction with the finance department. Benefit identification and realisation plans continue to be an active products within the Informatics.
Quality, Safety and Patient Experience Assessment	The Office of the CCIO & CNIO provide a more formal approach to the clinical safety of digital services and encompasses the management and investigation of clinical incidents. A National Welsh Clinical Information Council provides multi-disciplinary oversight.
Equality and Diversity Impact Assessment (including child impact assessment)	The strategy was subject to an equality and diversity impact assessment which covers all patient and staff groups in ABUHB.
Health and Care Standards	3.4 – Information Governance and Communications Technology 3.5 – Record Keeping
Link to Integrated Medium Term Plan/Corporate Objectives	The Digital Strategy has been approved and is referenced in the informatics IMTP.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term** – Patients will be enabled to coproduce their health care using technology to support well-being management, long-term health management and short-term episodes of illness or injury. A digitised framework will be provided within which Practitioners are able to interact with and empower their patients using a wider range of consulting, coaching and informatics skills. Practitioners will have access in real time to the information they need to treat and care for their patients releasing time to care from non-value adding work.
	Integration – Computing infrastructure will be ubiquitous and information collected joined up and available at each level of the organisation through to population health Patients will enjoy the benefits of integrated information and communication systems operating across primary, secondary and tertiary health care in Wales and across Health and Social Care public sector bodies, third sector and other health care settings.
	Involvement – ABUHB will have engaged leaders who are deeply knowledgeable about the clinical and technological systems in place with Chief Information and Chief Clinical

	Information Officers in place ensuring a digitally mature approach to service transformation.
	Collaboration – Informatics Directorate will have established long term relationships with academia, technology vendors and suppliers including consortia and small and medium enterprises, social care, third sector and other health organisations, patient representatives and other stakeholders delivering and demonstrating the benefits of innovative uses of informatics to enhance health care.
	Prevention – Informatics Directorate Service Management will provide a sustainable service that prevents and minimises the risk of service disruption and outages to clinical and operational environments through a service and appropriately qualified staff operating within best practice assurance frameworks.
Glossary of New Terms	
Public Interest	Can be published

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit, Finance & Risk Committee Thursday 8th April 2021 Agenda Item: 3.1

Finance, Audit & Risk Committee

Update on Governance, Financial Control Procedures and Technical Accounting Issues

Executive Summary

This report gives the Audit Committee an update in relation to a number of standing items which are reviewed in line with the committee's terms of reference and work plan:

- Governance Issues including Standing Orders (SOs) & Standing Financial Instructions (SFI's)
- Technical accounting issues
- Public Sector Payment Policy compliance
- Single Tender Actions
- Payments Exceeding £100K

The Audit Committee is requested to:

- Note the contents of this report.

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	

Executive Sponsor: Glyn Jones, Director of Finance and Performance

Report Author: Estelle Evans, Head of Financial Services and Accounting

Report Received consideration and supported by :

Executive Team		**Committee of the Board [Committee Name]**	

Date of the Report: 25th March 2021

Supplementary Papers Attached:

Appendix 1 – Single Tender Action

Purpose of the Report
To provide the Audit Committee with an update on the standing items listed in the Executive summary.
Background and Context
See Executive summary above.

Assessment and Conclusion

1. Review of Standing Orders, SFI's and Scheme of Delegation.

There is no further update in relation to this issue.

2. Technical Accounting Issues

2.1 IFRS16 Leases - update on action to date

There is no further update on IFRS16 with the implementation date for the Health Bodies in Wales confirmed as 1 April 2022.

2.2 VAT and the Public Sector – reform to VAT refund rules

As reported at the last Audit Committee a response has been submitted on behalf of all Welsh Health Boards/Trusts and SHA in support of the proposed changes.

No further information has been received to date regarding this issue.

2.3 Scheme Pays – Pension Tax impact on Clinicians

Welsh Government have requested the information from the Pensions Agency on behalf of all Welsh health bodies.

Audit Wales are now of the view that whilst they would consider the spend to be irregular they do not consider it to be material by value or nature so would not consider it a qualification issue should there be some expenditure

2.4 COVID19 Annual Leave Carry Forward

The Health Board have now received the resource funding in relation to the calculated accrual required in 2020/21 to reflect where it has not been possible for all annual leave to have been taken by the end of the financial year.
The All Wales Technical Accounting Group (TAG) agreed a common methodology to be applied when calculating the required accrual.

2.5 Revised treatment for 'free of charge' Personal Protective Equipment (PPE)

Audit Wales have confirmed that their view is that both the consumable (e.g. personal protective equipment) and non-consumable assets (e.g. beds) given to NHS Wales bodies free of charge should be reflected in the accounts of individual health bodies in a

way similar to the accounting for donated assets i.e. no overall impact on the reported position.

3. Public Sector Payment Policy

The following table shows the Public Sector Payment Policy performance for the month of February. The target of 95% has been achieved on a year to date basis.

Category	Invoices	In Mth %	YTD %
Non NHS	Value	96.8	95.4
	Number	96.3	96.4

4. Single Quotation and Tender Actions – 23rd January to 24th March 2021

All requests for a Single Tender Action or a Single Quotation action are submitted to the Chief Executive for approval and also reported to the Audit Committee.

There have been 14 requests submitted and approved during the period 23rd January 2021 to 24th March 2021 with a total value of £1.342m excluding VAT. Appendix 1 provides the full detail.

Of these 14 approved requests, 2 were classified as either licensing or maintenance/ service type arrangements, the scope of which could cover the on-going servicing / support of medical equipment, ICT Hardware/Software or general licensing. The remaining 12 were classified as goods purchased.

5. Payments In Excess of £100K

The table below shows the breakdown of payments made in the months of January & February 2021.

Payments in the period January & February 2021	**Number**	**Value**
Total Payments made	139	£128.553m
Specifically Agreed - Scheme of Delegation Payments	72	£108.303m
Payments Processed through Purchase Order Approval Process	37	£10.080m
Pharmacy Contractor Services Payments	30	£10.170m
Split of Revenue & Capital Payments	**Number**	**Value**
Payments from Capital Budget	25	£8.855m
Payments from Revenue Budget	114	£119.698m
Contractual Information for Private Sector Companies	**Number**	**Value**
Total Number of Payments to Private Sector Companies	47	£12.711m
Payments to Private Sector Companies where Contract was in place	47	£12.711m
Payments to Private Sector Companies where Contract not in place	0	£0m

In February, the process for paying the Pharmacy Contractor Services payments was transferred from NWSSP – Primary Care Services to NWSSP - Accounts Payable and is now processed via BACS through Oracle FMS. As such, these payments are now included within the table above.

Therefore there were no exceptional issues to report.

Recommendation
The Audit Committee is requested to: Note the contents of this report.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	*SFI's. SO's, Financial controls and accounting systems and processes form the basis of many organisational controls without which the organisation would be exposed to significant financial and reputational risk.*
Financial Assessment	*No direct financial implications but the financial governance issues covered in this standard Audit Committee paper set a framework of key financial controls for the organisation.*
Quality, Safety and Patient Experience Assessment	*Not applicable*
Equality and Diversity Impact Assessment (including child impact assessment)	*No adverse impact*
Health and Care Standards	*No applicable*
Link to Integrated Medium Term Plan/Corporate Objectives	*SFIs, SOs, Financial controls and accounting systems and processes form the basis of many organisational controls which form part of the delivery of financial targets and good governance.*
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*Not relevant*
Glossary of New Terms	*FCP – Financial Control Procedure* *SFIs - Standing Financial Instructions* *SOs - Standing Orders* *NWSSP - NHS Wales Shared Services Partnership*

Appendix 1 - Summary of Single Tender/Quotation Actions

Date of Request	Type of Request	Reference No	Description	Anticipated Annual Value (ex VAT)	Supplier	Type	Reason for request	Advice from Procurement	Approved / Rejected	CEO Approval Date
03/02/2021	Single Tender	ABU-STA-125349	Tracey Martin - Practicus	£31,984.23	Practicus LTD	Services	Supporting Theatre Scheduling and looking at Risk Stratification Guidance from Welsh Government - Extension of existing contract until 31/03/2021	Approved on the basis that the continuation of contract with the project and the relevant person with the comprehensive skill set required and knowledge of the project	Approved	01/02/2021
08/02/2021	Single Tender	ABU-STA-125386	First Clinical	£41,625.00	First Clinical	Services	Management of cancer pathway and patient safety on the pathway. To work closely with Cancer Services Team and directorate in formalising clinical pathways in order to maximise OPD/ Theatre Activity	Approved on the basis of continuation of current contract and to ensure compliance with Action Plan and WG Risk Stratification	Approved	01/02/2021
08/02/2021	Single Tender	ABU-STA-125389	Replacement Samsung Detector	£38,000.00	Canon Medical	Goods	The detector is specific to the Samsung Digital radiography room and can MIS Healthcare are the only providers of this equipment. They also hold the maintenance contract for the DR rooms so would take responsibility for maintenance.	Approved on the basis that the goods are specific for the requirements and MIS healthcare is the only provider	Approved	09/02/2021
08/02/2021	Single Tender	ABU-STA-46497	Centrifuge	£6,819.20	RMS Labcare	Goods	The current RMS Labcare Rotina centrifuge is regularly serviced and maintained, but due to its age replacement parts are impossible to obtain. Breakdowns are happening more frequently, with call out charges and effecting the efficiency and throughput. The department produces approximately 2,500 samples per year all of which are spun in the centrifuge. Implementation of the single cancer pathway, and a 4% annual increase in workload, has put increasing pressure on turnaround times. It is therefore vitally important that the department's centrifuge is reliable, and diagnostic cytology process is as efficient as possible in order to meet the required turnaround times and key performance indicators. There has also been an issue of the gas struts on the centrifuge failing causing injury to a member of staff, should this happen again there would be a serious health and safety issue. Procurement of this particular centrifuge would result in no additional training requirements and reduce maintenance cost as it can be bolted on to current maintenance and service requirements provided.	Approved on the basis of urgency of requirement	Approved	16/02/2021
09/02/2021	Single Tender	ABU-STA-125408	Cardioscan Cardiac Monitoring System	£89,970.00	Cardioscan	Services	Full cardio monitoring solution to support current ambulatory services which has a significant backlog from the current pandemic - only company able to provide examples of > single channel ECG which has been requested by clinicians, without compromising on patient application difficulty	Approved on the basis as only suitable provider	Approved	09/02/2021
11/02/2021	Single Tender	ABU-STA-46246	RGD King - cabling infrastructure	£500,000.00	RGD King	Services	Update to cabling infrastructure throughout the Aneurin Bevan Health Board hospitals	Approved on basis of previous work with supplier and only supplier within a suitable distance to carry out the works	Approved	11/02/2021
15/02/2021	Single Tender	ABU-STA-46549	Provision of kits for Genmark Eplex for Sars Cov2 testing.	£100,464.00	AB Scientific	Goods	To provide additional fast track covid testing for ABUHB	Approved on the basis of urgency of requirement	Approved	22/03/2021
08/02/2021	Single Tender	ABU-STA-124300	Optimusic	£32,000.00	Optimusic	Goods & Services	Only quotation obtained via Multiquote system	Approved on the basis of urgency of requirement	Approved	25/02/2021
24/02/2021	Single Tender	ABU-STA-46632	GUH Emergency Department Well-being & Home Safe Service	£177,000.00	British Red Cross	Services	Due to early opening of grange hospital the decision was made due to the needs of the service	Approved to extend with incumbent provider for 12 month period	Approved	04/03/2021
04/03/2021	Single Tender	ABU-STA-45732	GUH Minibus service	£232,560.00	Zeelo	Services	Transport Provision to support early opening of GUH	Approved on the basis of one suitable provider who could meet the needs of GUH early opening	Approved	02/11/2020
04/03/2021	Single Tender	ABU-STA-43853	Roots of empathy service	£45,000.00	Roots of empathy UK	Services	Mental Health Services	Approved on the basis of one suitable provider	Approved	16/02/2021
08/03/2021	Single Tender	ABU-STA-125934	Provision of Cerebral Function Monitoring equipment for use on Neonatal Intensive Care Unit, GUH:	£19,539.00	Belmont Medical Industries	Goods	Provision of Cerebral Function Monitoring equipment for use on Neonatal Intensive Care Unit, GUH: NATUS OLYMPIC BRAINZ MONITOR OBM WITH RECOGNIZE AND BPC This equipment is a simplified EEG device to monitor cerebral function at the cot side. It looks at the background electrical activity in the brain. Through monitoring and automated seizure detection, the data supports clinical decision making	Approved on the basis of the goods being the most suitable and reliable for the requirement	Approved	08/03/2021
25/02/2021	Single Quotation	ABU-SQA-46650	Osmometer for Special Chemistry	£11,250.00	Advanced Instruments	Goods	Replacement of old and broken equipment	Approved on the basis of continuity of service and maintaining standards	Approved	10/03/2021
12/03/2021	Single Quotation	ABU-SQA-46758	Swabs and UTM for POCT	£16,056.00	Sterilab Service	Goods	Guarantee supply for validated consumables required for POCT COVID testing	Approved on the basis of the goods being validated and approved for use	Approved	22/03/2021

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit, Finance & Risk Committee Thursday 8th April 2021 Agenda Item: 3.2

Finance, Audit & Risk Committee

Losses and Special Payments Report

Executive Summary

- **Purpose**
  To provide the Audit Committee with information in relation to financial losses and special payments made by the Health Board between 1st April 2020 and 28th February 2021.

- **Background and context**
  Losses and Special payments are reported in the financial position monthly and reported to the Audit Committee in line with the Committee's terms of reference.

  The main content of the report is in the Losses and Special Payments table and sets out the recorded "loss" for the year to date alongside where this category of expense is considered and scrutinised within the Health Board.

  The report also provides details of the provision held by the Health Board in relation to all outstanding Medical Negligence, Personal injury and redress claims which are currently under review. This provision is, in effect, a view into the future potential cost to the NHS in Wales of current cases.

- **Key Issues**
  The losses and special payments recorded during the period 1st April 2020 to 28th February 2021 totalled £10,977k of which £9,094k is recoverable from the Welsh Risk Pool (WRP), this means the actual loss to the Health Board is £1,883k.

  In addition to the cost recorded above, a provision for clinical negligence and personal injury cases is recorded on the balance sheet and is based on the estimated potential liability as advised by Welsh Health Legal Services of the maximum possible future cost for all known cases. It has reduced by £4.4m since 31st March 2020 to an overall provision of £163.7m of which it is expected that £158m is recoverable from WRP leaving a potential future loss to the Health Board of £5.6m

- **Recommendation**
  Audit Committee is asked to note the content of this report.

The Audit Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	
Executive Sponsor: Glyn Jones, Director of Finance and Performance	
Report Author: Estelle Evans, Head of Financial Services and Accounting	

Report Received consideration and supported by :			
Executive Team	**n/a**	**Committee of the Board [Committee Name]**	**n/a**
Date of the Report: 24th March 2021			
Supplementary Papers Attached:			

Purpose of the Report
To provide the Audit Committee with information in relation to financial losses and special payments made by the Health Board between 1st April 2020 and 28th February 2021.

Financial Implications

1 Financial Analysis of Losses

LOSSES AND SPECIAL PAYMENTS 01.04.20-28.02.21

	No. of Cases	Amount of Loss or Payment			Type of loss/payment	Where reported/reviewed	Notes
		ABUHB £'000	Welsh Risk Pool £'000	TOTAL £'000			
LOSSES:							
Bad Debts	18	0	0	0	Various	Authorised by Division and notified/approved by Audit Committee February 2021	18 cases relates to under £10 write offs - total value for all was £23.
SPECIAL PAYMENTS:							
Loss of personal effects	36	16	0	16	Minor Losses	Losses form completed - Authorised by Division and Putting Things Right team	Lost dentures, glasses etc.
Clinical negligence with advice	221	1,302	8,845	10,147	Clinical Negligence	Clinical negligence and personal injury - payment verified and lessons learnt addressed by the litigation committee for claims over £25K. Feedback into the quality and patient safety committee re Lessons Learnt. Reimbursement of payment made not processed by WRP until satisfied that lessons learnt have been clearly documented and implemented. Annual Report to Quality & Patient Safety Committee by the Litigation Department. Includes case type, numbers, financial information and historic comparisons.	Completed cases
Personal injury with advice (includes Permanent Injury Benefit)	73	524	95	619	Personal Injury	As above	Completed cases
Other clinical negligence and personal injury	44	34	154	188	Clinical Negligence and Personal Injury - claims under £25K	Redress committee for payments under £25K. Lessons learnt fed back to division	Completed cases
Other	9	6	0	6	Various	Ombudsman cases - confirmed by putting things right team, fire damage - losses report completed as appropriate	
TOTAL LOSSES AND SPECIAL PAYMENTS	**401**	**1,883**	**9,094**	**10,977**			
Of which, cases of £250,000 or more: Clinical negligence with advice	9	21	6,045	6,065			

2 Clinical Negligence and Personal Injury Provisions

The table below shows the analysis of the estimated liability for losses as at 28th February 2021 compared to the position reported at 31st March 2020. It reflects the estimated liability in relation to cases advised by Welsh Health Legal Services for both clinical negligence, personal injury and redress with the provision updated to reflect new or changed cases.

After the expected recoveries from the Welsh Risk Pool are taken in to account the estimated liability to the Health Board at the end of February 2021 is £5,640k.

Losses & Special Payments Provisions	**31-Mar-20**		**28-Feb-21**	
	No. of Cases	**£000**	**No. of Cases**	**£000**
Clinical Negligence	245	163,277	243	159,470
Personal Injury	84	591	67	333
Permanent Injury Benefit	22	3,612	22	3,353
Redress	39	546	44	499
Sub Total	**390**	**168,026**	**376**	**163,655**
Less WRP Recoverable: Clinical Negligence	-116	-161,285	-116	-157,492
Less WRP Recoverable: Personal Injury	-5	-192	-5	-55
Less WRP Recoverable: Redress	-37	-494	-44	-468
Net Liability	**232**	**6,055**	**211**	**5,640**

Recommendation
The Audit Committee is asked to note the contents of the report.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	N/A
Financial Assessment	*The financial impact is reflected in the monthly reported financial position.*
Quality, Safety and Patient Experience Assessment	*N/A*

Equality and Diversity Impact Assessment (including child impact assessment)	*N/A*
Health and Care Standards	*N/A*
Link to Integrated Medium Term Plan/Corporate Objectives	*N/A*
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*N/A*
Glossary of New Terms	*None*
Public Interest	*Report to be published in the public domain.*

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit, Finance & Risk Committee Thursday, 8th April 2021 Agenda Item: 3.3

Finance, Audit & Risk Committee

Aneurin Bevan University Health Board - Response to Audit Wales (AW) for matters in relation to fraud, laws & regulations and related parties.

Executive Summary

As part of the accounts sign off process each year, Audit Wales need to ensure compliance with International Standards for Auditing. As such, they request documented consideration from management and those charged with governance (Board and Audit Committee) on a range of questions relating to:

- Fraud
- Laws and regulations
- Related Parties

The attached document has been completed by relevant managers and the previous year's responses are included for information.

The responses were considered and approved by the Executive Team on 22 March 2021

The Audit Committee are asked to approve the responses prior to submission to Audit Wales as part of the year end accounts process.

The Board is asked to: (please tick as appropriate)	
Approve the Report	✓
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	

Executive Sponsor: Glyn Jones, Director of Finance and Procurement

Report Author: Mark Ross, Assistant Director of Finance (Financial Systems & Services)

Report Received consideration and supported by :

Executive Team		**Committee of the Board [Committee Name]**	**Audit Committee**

Date of the Report:25/3/21

Supplementary Papers Attached:
ABUHB responses

Recommendation
The Committee are asked to review the responses and approve.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Part of the accounts sign off process
Financial Assessment	*No direct financial implications*
Quality, Safety and Patient Experience Assessment	*No direct implications*
Equality and Diversity Impact Assessment (including child impact assessment)	*No adverse impact*
Health and Care Standards	*Not applicable.*
Link to Integrated Medium Term Plan/Corporate Objectives	*Having an agreed IMTP is a core statutory financial duty which is disclosed in the financial statements.*
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*Not relevant*
Glossary of New Terms	

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Mr Glyn Jones
Executive Director of Finance and Performance
Aneurin Bevan University Health Board

Reference: TCWG 20-21

Date issued: 9 February 2021

Dear Glyn

Aneurin Bevan University Health Board 2020-21

Audit enquiries to those charged with governance and management

As in previous years, you will be aware that I am responsible for obtaining reasonable assurance that the financial statements taken as a whole are free from material misstatement, whether caused by fraud or error. In accordance with the requirements set out in International Standards on Auditing (ISAs), I am writing to you to formally seek your documented consideration and understanding on a number of governance areas that impact on my audit of your financial statements. These considerations are relevant to both the management of the offices of the Health Board and 'those charged with governance'.

I have set out below the areas of governance on which I am seeking your views.

1. Management processes in relation to:

   – undertaking an assessment of the risk that the financial statements may be materially misstated due to fraud;

   – identifying and responding to risks of fraud in the organisation;

   – communication to employees of views on business practice and ethical behaviour; and

– communication to those charged with governance of the processes for identifying and responding to fraud.

2. Management's awareness of any actual or alleged instances of fraud.

3. How management gain assurance that all relevant laws and regulations have been complied with.

4. Whether there is any potential litigation or claims that would affect the financial statements.

5. Management processes to identify, authorise, approve, account for and disclose related party transactions and relationships.

The information you provide will inform our understanding of the Health Board's arrangements and business processes and support our work in providing an audit opinion on their 2020-21 financial statements.

I would be grateful if you could complete the attached table in **Appendices 1, 2** and **3**, which should be formally considered and communicated to us on behalf of both management and 'those charged with governance' (the Board and Audit Committee).

Your responses should be formally considered and communicated to us on behalf of both management and those charged with governance by 1 May 2021.

If you have any queries, please contact Tracy Veale on 02920 320596 or by e-mail on tracy.veale@audit.wales.

Yours sincerely

Richard Harries
Engagement Director

Appendix 1

Matters in relation to fraud

International Standard for Auditing (UK and Ireland) 240 covers auditors' responsibilities relating to fraud in an audit of financial statements.

The primary responsibility to prevent and detect fraud rests with both management and 'those charged with governance', which for the Health Board is the Board. Management, with the oversight of the Board, should ensure there is a strong emphasis on fraud prevention and deterrence and create a culture of honest and ethical behaviour, reinforced by active oversight by those charged with governance.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error. We are required to maintain professional scepticism throughout the audit, considering the potential for management override of controls.

What are we required to do?

As part of our risk assessment procedures we are required to consider the risks of material misstatement due to fraud. This includes understanding the arrangements management has put in place in respect of fraud risks. The ISA views fraud as either:

- the intentional misappropriation of assets (cash, property, etc); or
- the intentional manipulation or misstatement of the financial statements.

We also need to understand how the Board exercises oversight of management's processes. We are also required to make enquiries of both management and the Board as to their knowledge of any actual, suspected or alleged fraud. for identifying and responding to the risks of fraud and the internal controls established to mitigate them.

Enquiries of management - in relation to fraud		
Question	**2019-20 Response**	**2020-21 Response**
1. What is management's assessment of the risk that the financial statements may be materially misstated due to fraud and what are the principal reasons?	Management's assessment is that, as in previous years, the risk of misstatement remains low. The basis being an effective system of internal controls and sound control environment mitigate against the risk. This is supported by Internal Audit reports and the Head of Internal Audit Opinion.	Management's assessment is that, as in previous years, the risk of misstatement remains low. The basis being an effective system of internal controls and sound control environment mitigate against the risk. This is supported by Internal Audit reports and the Head of Internal Audit Opinion. Although the Covid-19 pandemic has meant that, at times, some decisions have been made at pace, this has been within an agreed governance structure with appropriate controls in place. Temporary amendments to the scheme of delegation were made relating to Covid expenditure limits. These limits were approved by and reviewed by the Board regularly throughout the year. Decisions made using these revised limits are routinely reported to the Audit Committee.

2. What processes are employed to identify and respond to the risks of fraud more generally and specific risks of misstatement in the financial statements?	In light of the COVID-19 crisis, all the indicators from the WG, the Government Counter Fraud Function and the NHS Counter Fraud Authority is that fraud risks are currently high and the economic attack against the NHS and other public sector bodies will increase. The ABUHB LCFS is working in close collaboration with NWIS to combat malware attack, and with Procurement Services & Corporate Finance to mitigate supplier fraud, invoice fraud and banking mandate fraud. Positive intervention has already taken place in ABUHB in relation to supplier fraud whereby the supply of critical clinical equipment has been tendered, the sourcing and supply of which was doubtful. The LCFS is also working in conjunction with Payroll Services to prevent salary diversion fraud to protect staff from fraud. Continuous feedback on identified and emerging fraud threats is vital to the ABUHB organisation, Internal Audit, NHSCFA, the Government Counter Fraud Function and the WG, as such feedback serves to protect the ABUHB organisation and the wider NHS family and other public sector bodies from economic crime. There are a series of Financial Control procedures covering all main financial	In light of the COVID-19 crisis, all the indicators from the WG, the Government Counter Fraud Function and the NHS Counter Fraud Authority is that fraud risks are currently high and the economic attack against the NHS and other public sector bodies will increase. The ABUHB LCFS is working in close collaboration with NWIS to combat malware attack, and with Procurement Services & Corporate Finance to mitigate supplier fraud, invoice fraud and banking mandate fraud. This area of Procurement fraud remains arguably the greatest current threat with the highest likelihood and consequence rating. Positive intervention has already taken place in ABUHB in relation to supplier fraud whereby the supply of critical clinical equipment has been tendered, the sourcing and supply of which was doubtful. The LCFS has reviewed Procurement controls in relation to pre-contract fraud and invoice fraud and risk assessments have been undertaken accordingly with a positive outcome. The organisation continues to experience attacks from invoice and banking mandate fraud and thus far, existing controls have been effective in combatting these attacks. A similar review has been implemented in relation to non-cash income handling by Charitable Funds with a positive outcome.

	systems, such as general ledger, banking, payables, receivables that are approved by the Audit Committee. Each FCP sets out procedures aimed at minimising fraud and error and each procedure is subject to internal audit and to a level of external audit testing. Review of Financial Control Procedures is reported as part of a standard governance paper to each Audit Committee so that policies are regularly reviewed and scrutinised. The organisation is vigilant to the threat of fraud and segregation of duties is implemented to mitigate fraud risk. Segregation of duties is encapsulated within Financial Control Procedures for the Board's core financial systems and is subject to regular audit to ensure that both system design is robust and that policies are complied with operationally. There is a high degree of scrutiny of financial statements, on a monthly basis, at budget holder, business partner, and management team, as well as executive and board level. Variances are fully investigated and any unusual and material transactions should be uncovered through this process. Through the year-end accounts production process there is a detailed review of financial statements compared to the previous year,	The LCFS is also working in conjunction with Payroll Services to prevent salary diversion fraud to protect staff from fraud. Continuous feedback on identified and emerging fraud threats is vital to the ABUHB organisation, Internal Audit, NHSCFA, the Government Counter Fraud Function and the WG, as such feedback serves to protect the ABUHB organisation and the wider NHS family and other public sector bodies from economic crime. Indications are that fraudsters are becoming smarter and faster with online fraud increasing during the Covid pandemic. HMR&C fraud scams targeting both NHS Staff & the general public have been experienced together with offers to sell Covid vaccine to the general public and attempts to purchase vaccine at GMS level. A new online theme was attempts to instigate password changes to E-expenses at NHS staff level. There are a series of Financial Control procedures covering all main financial systems, such as general ledger, banking, payables, receivables that are approved by the Audit Committee. Each FCP sets out procedures aimed at minimising fraud and error and each procedure is subject to internal audit and to a level of external audit testing. Review of Financial Control

	with any movements fully explained and a report shared with the Audit Committee. The Health Board Finance team provide full access to all financial data to the Audit Wales audit team by giving access to the Finance Business Intelligence QlikView reporting tool to ensure full visibility of all health board financial transactions and accounting. The Counter Fraud provision in ABUHB is highly effective with four criminal convictions for fraud being successfully pursued during 2019/20, plus two further impending prosecutions currently awaiting hearings in criminal court. Such criminal sanctions have a deterrent impact to any would-be NHS fraudster. This is supplemented by a high profile and continuous fraud awareness rolling programme which reinforces the deterrent message that fraud against the NHS is unacceptable, indefensible and will not be tolerated and that action will be taken against any known perpetrators.	Procedures is reported as part of a standard governance paper to each Audit Committee so that policies are regularly reviewed and scrutinised. The organisation is vigilant to the threat of fraud and segregation of duties is implemented to mitigate fraud risk. Segregation of duties is encapsulated within Financial Control Procedures for the Board's core financial systems and is subject to regular audit to ensure that both system design is robust and that policies are complied with operationally. There is a high degree of scrutiny of financial statements, on a monthly basis, at budget holder, business partner, and management team, as well as executive and board level. Variances are investigated and any unusual and material transactions should be uncovered through this process. Through the year-end accounts production process there is a detailed review of financial statements compared to the previous year, with any movements fully explained and a report shared with the Audit Committee. Arrangements are in place, as last year, to ensure Audit Wales have full access to financial information even though they (Audit Wales) are not able to work on site. There are also regular meetings using Teams

		between the Health Board and Audit Wales to ensure any issues are resolved quickly. The Counter Fraud provision in ABUHB is highly effective with two criminal convictions for fraud being successfully pursued during 2020/21, plus further cases awaiting charging decisions with the CPS. Such criminal sanctions have a deterrent impact to any would-be NHS fraudster. This is supplemented by a high profile and continuous fraud awareness rolling programme which reinforces the deterrent message that fraud against the NHS is unacceptable, indefensible and will not be tolerated and that action will be taken against any known perpetrators.

Enquiries of management - in relation to fraud		
Question	**2019-20 Response**	**2020-21 Response**
3. What arrangements are in place to report fraud issues and risks to the Audit Committee?	The Audit Committee members meet privately with Internal Audit, External Audit and Counter Fraud through the financial year, where any concerns can be raised without the presence of management. The Head of Counter Fraud regularly presents update reports to the Audit Committee of active and closed investigations. The Head of Counter Fraud is able to contact the Audit Committee members at any time and not just at the pre-arranged meetings with members of the Audit Committee. The private meetings with independent members demonstrate organisational probity.	The Audit Committee members meet privately with Internal Audit, External Audit and Counter Fraud through the financial year, where any concerns can be raised without the presence of management. The Head of Counter Fraud regularly presents update reports to the Audit Committee of active and closed investigations. The Head of Counter Fraud is able to contact the Audit Committee members at any time and not just at the pre-arranged meetings with members of the Audit Committee. The private meetings with independent members demonstrate organisational probity.

Enquiries of management - in relation to fraud		
Question	**2019-20 Response**	**2020-21 Response**
4. How has management communicated expectations of ethical governance and standards of conduct and behaviour to all relevant parties, and when?	During 2019/2020, the Audit Committee approved a new Declarations of Interest and Business Conduct Policy (October 2019). Prior to this approval the policy was supported by the Workforce Policy Group and the Trade Union Partnership Forum. The new policy has been communicated throughout the organisation and published on a dedicated Health Board intranet page with other supporting resources. The Audit Committee also receives a report annually on Declaration of Interests (February 2020). The declarations of Board Members are also reported in the Health Board's Annual Governance Statement and Accounts. All Board members are circulated with a direct request, which forms the basis of the report. Also, additional awareness raising has been undertaken with Health Board staff and clinicians. The Business Conduct Policy and the arrangements for a declaration of interest disclosure now form	The Business Conduct Policy and the arrangements for a declaration of interest disclosure form part of the PADR process for Health Board staff and all line managers are required to engage with staff on these matters as part of this process. The declarations process will form part of any transaction process whereby, staff will be required to declare an interest with any party offered contractual business. All Board members have been provided with a direct request and pro forma to provide their declarations of interest; this forms the basis of the report.

Enquiries of management - in relation to fraud		
Question	**2019-20 Response**	**2020-21 Response**
	part of the PADR process in the Health Board and all line managers are required to engage with staff on these matters as part of this process. The Medical Director and Board Secretary have also written to all Health Board Consultants reminding them of the requirement to consider and submit declarations of interest.	
5. Are you aware of any instances of actual, suspected or alleged fraud within the audited body since 1 April 2020?	There have been 51 instances of suspected fraud reported to Audit Committee during this period (including cases brought forward from 2018/19). These cases attracted recoveries circa £6,000. Forty of those cases involved staff-related issues which, for the most part, the main categories were: working whilst on sick leave, falsification of timesheets/ expenses and one dishonest retention of an erroneous salary overpayment. The remainder of the cases involved alleged fraud on the part NHS primary care contractors and members of the public.	There have been 47 instances of suspected fraud reported to Audit Committee during this period (including cases brought forward from 2019/20). These cases attracted recoveries of £45,000. The majority of those cases involved staff-related issues which, for the most part, the main categories were: working whilst on sick leave, falsification of timesheets/expenses and dishonest retention of erroneous salary overpayments. The remainder of the cases involved alleged fraud on the part NHS primary care contractors and members of the public.

Enquiries of management - in relation to fraud		
Question	**2019-20 Response**	**2020-21 Response**
6. Are you aware of any fraud within the Shared Services since 1 April 2020?	Any suspected or alleged fraud in NWSSP has been reported to that body's Audit Committee by the Manager of Counter Fraud C&VUHB, from whom NWSSP receive Counter Fraud service provision. Irrespective of this, the ABUHB LCFS has an active and operational working relationship with Procurement Services and Payroll Services as outlined in response to Question 2 above. There have been numerous economic attacks relating to banking mandate fraud, invoice fraud, supplier fraud and salary diversion fraud, all of which have been intercepted and unsuccessful. The ABUHB LCFS has submitted a file of evidence to the CPS for a charging decision in relation to an alleged fraudulent attempt to register on the Welsh GP Performers list via NWSSP Contractor Services.	Any suspected or alleged fraud in NWSSP has been reported to that body's Audit Committee by the Manager of Counter Fraud C&VUHB, from whom NWSSP receive Counter Fraud service provision. Irrespective of this, the ABUHB LCFS has an active and operational working relationship with Procurement Services and Payroll Services as outlined in response to Question 2 above. There have been numerous economic attacks relating to banking mandate fraud, invoice fraud, supplier fraud and salary diversion fraud, all of which have been intercepted and unsuccessful

Enquiries of those charged with governance – in relation to fraud		
Question	**2019-20 Response**	**2020-21 Response**
1. How does the Board, exercise oversight of management's processes for identifying and responding to the risks of fraud within the audited body and the internal control that management has established to mitigate those risks?	The Audit Committee approves all changes to Financial Control procedures which are reviewed every three years. Each FCP of core financial systems are subject to regular internal audit with reports and considered by the Committee. Key risk areas such as high value transactions, single tender contracts and contracts against high value payments are considered at each Audit Committee meeting. If instances of fraud are detected, there is a link into the internal audit process where further work may be undertaken to ensure system weaknesses are reviewed and addressed.	The Audit Committee and Executive Team approve all changes to Financial Control Procedures which are reviewed every three years. Each FCP of core financial systems are subject to regular internal audit with reports and considered by the Committee. Key risk areas such as high value transactions, single tender contracts and contracts against high value payments are considered at each Audit Committee meeting. If instances of fraud are detected, there is a link into the internal audit process where further work may be undertaken to ensure system weaknesses are reviewed and addressed.
2. Are you aware of any instances of actual, suspected or alleged fraud	There have been a number of financial frauds that have been reported to the Audit Committee. All	There have been a number of financial frauds that have been reported to the Audit Committee. All

with the audited body since 1 April 2020?	cases are reported regularly as part of Counter Fraud reporting to the Audit Committee. Where instances of fraud have been discovered and which has highlighted a system weakness, these are addressed. System weaknesses identified from proactive preventative work undertaken by Counter Fraud are also reported to Audit Committee and remedial measures are implemented accordingly. This reporting also highlighted current fraud trends such as cyber fraud, banking mandate fraud and fraudulent invoicing and the risk and vulnerabilities attached to those domains.	cases are reported regularly as part of Counter Fraud reporting to the Audit Committee. Where instances of fraud have been discovered and which has highlighted a system weakness, these are addressed. System weaknesses identified from proactive preventative work undertaken by Counter Fraud are also reported to Audit Committee and remedial measures are implemented accordingly. This reporting also highlighted current fraud trends such as cyber fraud, banking mandate fraud and fraudulent invoicing and the risk and vulnerabilities attached to those domains.

Appendix 2

Matters in relation to laws and regulations

International Standard for Auditing (UK and Ireland) 250 covers auditors' responsibilities to consider the impact of laws and regulations in an audit of financial statements.

Management, with the oversight of those charged with governance, the Board, is responsible for ensuring that the Health Board's operations are conducted in accordance with laws and regulations, including compliance with those that determine the reported amounts and disclosures in the financial statements.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error, taking into account the appropriate legal and regulatory framework. The ISA distinguishes two different categories of laws and regulations:

- laws and regulations that have a direct effect on determining material amounts and disclosures in the financial statements; and
- other laws and regulations where compliance may be fundamental to the continuance of operations, or to avoid material penalties.

What are we required to do?

As part of our risk assessment procedures, we are required to make inquiries of management and the Board as to whether the Health Board is in compliance with relevant laws and regulations. Where we become aware of information of non-compliance or suspected non-compliance we need to gain an understanding of the non-compliance and the possible effect on the financial statements.

Enquiries of management – in relation to laws and regulations		
Question	**2019-20 Response**	**2020-21 Response**
1. How have you gained assurance that all relevant laws and regulations have been complied with?	The Health Board has in place a database which logs all new legislation and Welsh Health Circulars as they are received. Also, legislation and regulations are part of the scopes of external and internal audit reviews and are checked as part of these reviews. A national review, led by the Corporate Team at Betsi Cadwaladr University Health Board, was completed and discussions are underway with NHS Shared Services Legal Services to explore the opportunity for accessing a service to provide regular updates to NHS organisations in Wales, when legal changes have occurred through legislation and case law.	Compliance with legislation and regulations form part of the scopes of external and internal scrutiny bodies reviews. Compliance with major new or revised legislation and regulation are reported as separate items to various Executive Groups and Board Committees.
2. Have there been any instances of non-compliance or suspected non-compliance with relevant laws and regulations since 1 April 2020, or earlier with an ongoing impact on the 2020-21 financial statements?	There are no issues to report.	None reported

Enquiries of management – in relation to laws and regulations		
Question	**2019-20 Response**	**2020-21 Response**
3. Are there any potential litigations or claims that would affect the financial statements?	These are already reflected in the financial statements	None that are not already reflected in the financial statements.
4. Have there been any reports from other regulatory bodies, such as HM Revenues and Customs which indicate non-compliance?	HMRC have concluded the review referred to in the 2018/19 response. They have not charged the Health Board any penalties (which they are entitled to do) on the basis that we provide additional VAT training and guidance to staff and undertake regular reviews of any large new contracts. Since many of these arrangements were entered into, the Health Board has appointed an in-house VAT specialist who has been liaising with and is well respected by HMRC. We have already started working towards implementing procedures which will meet HMRC recommendations.	HMRC continue to undertake routine compliance reviews which, in line with VAT legislation, can cover a four-year period. Progress on these was suspended by HMRC due to Covid for the first half of the financial year, therefore none have been concluded since the last response. However, all of the in-house procedures previously detailed have been implemented to HMRC's satisfaction, and we expect that HMRC's ongoing reviews will find current transactions to be largely compliant.

Enquiries of management – in relation to laws and regulations		
Question	**2019-20 Response**	**2020-21 Response**
	• VAT training has been, and will continue to be, provided to groups of Health Board staff. Initially, this has taken place within Finance and procurement, but will be extended to other areas where it is found to be appropriate. • Guidance will shortly be available on Sharepoint. • The correct VAT treatment of regular charges is already being queried prior to the raising of invoices, and we are formalising the record keeping for this process. • Finally, from December 2019, income reports are being produced for checking as part of our routine monthly procedures.	

Enquiries of management – in relation to laws and regulations		
Question	**2019-20 Response**	**2020-21 Response**
1. Are you aware of any non-compliance with laws and regulations within Shared Services since 1 April 2020?	There are no issues to report.	There are no issues to report.

Enquiries of those charged with governance – in relation to laws and regulations		
Question	**2019-20 Response**	**2020-21 Response**
1. How does the Board, in its role as those charged with governance, obtain assurance that all relevant laws and regulations have been complied with?	The Health Board has in place a database which logs all new legislation and Welsh Health Circulars as they are received. Also, legislation and regulations are part of the scopes of external and internal audit reviews and are checked as part of these reviews. A national review, led by the Corporate Team at Betsi Cadwaladr University Health Board, was completed and discussions are underway with NHS Shared Services Legal Services to explore the opportunity for accessing a service to provide regular updates to NHS organisations in Wales, when legal changes have occurred through legislation and case law.	Compliance with legislation and regulations form part of the scopes of external and internal scrutiny bodies reviews. In addition, compliance and progress to compliance with major new or revised legislation and regulation are reported as separate items to various Executive Groups and Board Committees. These in turn are scrutinised by the Board Members and officers of the organisation.
2. Are you aware of any instances of non-compliance with relevant laws and regulations?	There are no issues to report.	None reported

Appendix 3

Matters in relation to related parties

International Standard for Auditing (UK and Ireland) 550 covers auditors responsibilities relating to related party relationships and transactions.

The nature of related party relationships and transactions may, in some circumstances, give rise to higher risks of material misstatement of the financial statements than transactions with unrelated parties.

Because related parties are not independent of each other, many financial reporting frameworks establish specific accounting and disclosure requirements for related party relationships, transactions and balances to enable users of the financial statements to understand their nature and actual or potential effects on the financial statements. An understanding of the entity's related party relationships and transactions is relevant to the auditor's evaluation of whether one or more fraud risk factors are present as required by ISA (UK and Ireland) 240, because fraud may be more easily committed through related parties.

What are we required to do?

As part of our risk assessment procedures, we are required to perform audit procedures to identify, assess and respond to the risks of material misstatement arising from the entity's failure to appropriately account for or disclose related party relationships, transactions or balances in accordance with the requirements of the framework.

Enquiries of management – in relation to related parties		
Question	**2019-20 Response**	**2020-21 Response**
1. Confirm that you have disclosed to the auditor: • the identity of any related parties, including changes from the prior period; • the nature of the relationships with these related parties; and • details of any transactions with these related parties entered into during the period, including the type and purpose of the transactions.	These will be provided as part of the annual accounts and associated statements.	These will be provided as part of the annual accounts and associated statements.
2. What controls are in place to identify, authorise, approve, account for and disclose related party transactions and relationships?	The corporate governance team works with the finance team to cross reference the Declarations of Interest Register to the related party disclosures that are published in the accounts to ensure completeness.	The corporate governance team works with the finance team to cross reference the Declarations of Interest Register to the related party disclosures that are published in the accounts to ensure completeness.

Enquiries of those charged with governance – in relation to related parties		
Question	**2019-20 Response**	**2020-21 Response**
1. How does the Board, in its role as those charged with governance, exercise oversight of management's processes to identify, authorise, approve, account for and disclose related party transactions and relationships?	The Audit Committee receives a report annually on Declaration of Interests and has approved a new policy in October 2019 to guide these processes. The declarations of Board Members are also reported in the Health Board's Annual Governance Statement and Accounts. All Board members are circulated with a direct request, which forms the basis of the report. Also, additional awareness raising has been undertaken with Health Board staff and clinicians. The Business Conduct Policy and declarations of interest disclosure requirements form part of the PADR process in the Health Board and all line managers are required to engage with staff on these matters as part of this process. The Medical Director and Board Secretary have also written to all Health Board Consultants reminding them of the requirement to consider and submit declarations of interest.	The Audit Committee receives a report annually on Declaration of Interests. The declarations of Board Members are also reported in the Health Board's Annual Governance Statement and Accounts.

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Audit, Finance & Risk Committee Thursday 8th April 2021 Agenda Item: 4.1

Aneurin Bevan University Health Board

Annual Counter Fraud Bribery & Corruption Report 2020/21

Executive Summary			
An executive overview has been prepared for the Aneurin Bevan University Health Board (ABUHB) Audit Committee. It highlights the Counter Fraud work conducted by the Local Counter Fraud Specialist (LCFS) for 2020/21.			
The Board is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views			√
Receive the Report for Assurance/Compliance			
Note the Report for Information Only			√
Executive Sponsor: Glyn Jones - DoF			
Report Author: Martyn Edwards – Head of Counter Fraud			
Report Received consideration and supported by : DoF			
Executive Team		**Committee of the Board [Committee Name]**	**Audit Committee**
Date of the Report: 18th March 2021			
Supplementary Papers Attached: No			

Purpose of the Report

To comply with the below legal directions which require the LCFS to provide a written report to the LHB (at least annually) on Counter Fraud work and to illustrate compliance, outcomes and learning under the Standards for NHS Bodies (Wales).

Background and Context

This report is in accordance with the Welsh Government Directions to NHS Bodies on Counter Fraud Measures WHC (2005) 095 under the provisions of the National Health Service Act 1977. This work is also undertaken in compliance with the counter fraud bribery and corruption measures under the Minister for Health and Social Service Directions and the service agreement between the NHS Counter Fraud Authority under S.83 of the Government of Wales Act 2006.

Assessment and Conclusion

This report will form the basis of the Quality Assurance Self-Review as evidence that the LHB has complied with the Standards for NHS Bodies (Wales). The report content and style complies with the model prescribed by the (NHSCFA) for Quality Assurance Assessment.

Recommendation

This report is intended for Audit Committee information and views.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	N/A
Financial Assessment, including Value for Money	N/A
Quality, Safety and Patient Experience Assessment	N/A
Equality and Diversity Impact Assessment (including child impact assessment)	N/A
Health and Care Standards	N/A
Link to Integrated Medium Term Plan/Corporate Objectives	N/A
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** N/A
	Integration – N/A
	Involvement – N/A
	Collaboration – N/A
	Prevention – N/A
Glossary of New Terms	N/A
Public Interest	N/A

ABUHB Finance, Audit & Risk Committee
Date: 8th April 2021
Agenda item 4.1

On behalf of

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

COUNTER FRAUD BRIBERY & CORRUPTION REPORT

1st April 2020 to 31st March 2021

Martyn Edwards
Head of Counter Fraud
Aneurin Bevan University Health Board

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1. Management Summary

1.1. The annual report for the period 1st April 2020 to 31st of March 2021 has been written in accordance with the provisions of the WG Directions on Counter Fraud Measures (WHC 095 of 2005) which require Local Counter Fraud Specialists (LCFS) to provide a written report, at least annually, to the LHB on Counter Fraud work. The report content and style used complies with the model prescribed by the NHS Counter Fraud Authority (NHSCFA) formerly NHS Protect and predecessor organisation NHS Counter Fraud Security Management Service (CFSMS).

1.2. Effective from April 2010, Martyn Edwards was appointed as Head of Counter Fraud for Aneurin Bevan LHB and assumed the role of Lead LCFS assisted by a support LCFS.

1.3. The reorganisation of the NHS in Wales and the resulting redeployment of BSC LCFS staff left the Counter Fraud provision with a deficiency of one WTE LCFS for year 2010/11. That aspect was redressed in 2011 and a new WTE LCFS i.e. Joanne Bodenham was appointed which impacted upon year 2011 onwards.

1.4. Martyn Edwards completed his Counter Fraud training in February 2009 and was accredited in March 2009. Joanne Bodenham completed her Counter Fraud training in 2011 and became accredited that same year. As a replacement team member, Gareth Lavington was appointed on 4th November 2019, and has successfully completed the National Counter Fraud Foundation Training. This resulted in University approval for accreditation as a Counter Fraud Specialist with the Professional Accreditation Board and subsequent nomination as a Counter Fraud Specialist with the NHSCFA on 6th January 2021.

1.5. In total 590 Counter Fraud days were provided for Aneurin Bevan University Health Board during 2020/21. This breaks down across the standards key framework as follows: Strategic = 138 days, Inform & Involve = 71 days, Prevent & Deter = 99 days, Hold to Account = 282 days.

1.6. The aforementioned provision of Counter Fraud days was devoted to a workplan which contained 535 days spread across the key framework which was provided by 2.8 WTE LCFS's as defined in the corporate structure outline. Therefore the actual number of days provided by the LCFS for 2020/21 exceeded the expectation of the workplan by 55-days. The workplan itself was approved by the DoF in accordance with the legal directions and the NHS counter fraud manual and the workplan was ratified by Audit Committee.

1.7. During the period 1st April 2020 to 31st March 2021, Aneurin Bevan University Health Board Counter Fraud team handled **forty-eight (48)** investigations into potential fraudulent or corrupt activity, which included cases brought forward from 2019/20. These cases are listed at **Appendix 2** (index of investigations).

1.8. **Thirty-four (34)** of those cases involved instances of staff related issues, which for the most part, the main categories were working whilst on sick leave, falsification of timesheets/expenses and dishonest retention of erroneous salary overpayments. The remainder of the cases involved alleged fraud on the part NHS primary care contractors and members of the public. For example, case number **eleven (11)** on **Appendix 2** pertains to a member of the public recently convicted of NHS fraud.

1.9. The aforementioned investigations have resulted in **seven (7)** files of evidence being forwarded to the Crown Prosecution Service for charging decisions. The LCFS investigations have also resulted in **six (6)** disciplinary sanctions during

2020/21, predominately resulting in dismissal from employment with ABUHB for gross misconduct and/or sanctions by a professional body.

1.10. Furthermore, investigation numbers **(17)** & **(31)** are impending criminal prosecutions. Investigation numbers **(11)** & **(14)** resulted in criminal convictions at court (total 2 criminal sanctions plus 2 impending prosecutions).

1.11. Financial recoveries stemming from LCFS investigations during 2020/21 stand at **£47,443.54.**

1.12. Appendix 2 (schedule of investigations) depicts that similar to year 2019/20, in comparison to previous years, overpayment of salaries for personnel who have terminated employment with the organisation (which have potential implications for criminal proceedings) remains at a low level. This report incorporates only two such investigations of that nature and this may possibly be viewed as assurance, insomuch as despite overpayments occurring in high volume for existing staff, salary overpayments for terminated staff remain low. As in previous years, the LCFS has continued to work in close liaison with NWSSP Payroll Services, NWSSP Accounts Payable staff and also ABUHB Accounts Receivable Staff from Corporate Finance. Intranet guidance has been reiterated to managers to remedy this, emphasising the crucial requirement for timely and accurate staff termination forms and staff changes forms to be disseminated to Payroll Services. One such example is a reminder to this effect on the ABUHB Intranet carousel in March 2021. To reinforce this principle, payslip messages have historically been disseminated to all staff advising of the potential criminal liability of the wilful retention of erroneous salary overpayments, and likewise on the intranet carousel. The implementation of the ABUHB Recovery of Overpayments Policy is promoted by Corporate Finance and the LCFS alike and is rigidly adhered to. All overpayments, regardless of origin, are notified to the LCFS by Corporate Finance/Payroll Services/Accounts Receivable staff. The ABUHB Recovery of Overpayments Policy is up-to-date and fit for purpose. This Policy, in conjunction with the Counter Fraud, Bribery & Corruption Policy, acts as a sanction and redress policy on behalf of the organisation. Counter Fraud guidance features throughout the Recovery of Overpayments Policy and in the action flowchart which is incorporated within the policy.

1.13. On 10th March 2021, the LCFS requested the implementation of a speculative alert on ESR to electronically highlight staff payslips which go unopened on the system for a prolonged period of time. The purpose of this request is it could be an indicator that the staff member no longer works for the organisation yet is still being paid due to a failure in submission of a termination form to Payroll Services.

1.14. The mix of cases investigated to date are summarised in **Appendix 1** and a full index of cases reported/referred to the LCFS' are listed in **Appendix 2**.

1.15. During year 2020/21, the ABUHB LCFS has conducted **two (2)** tape recorded interviews under caution with **two (2)** alleged offenders. This number of interviews is reduced from previous years as a consequence of Covid restrictions.

2. Strategic Governance

2.1 The NHS Counter Fraud Authority developed standards for NHS Bodies (Wales) for fraud, bribery and corruption which were implemented in 2013/14. This was created in accordance with Minister for Health and Social Service Directions and the service agreement between the Welsh Government (WG) and the NHS Counter Fraud Service under S.83 of the Government of Wales Act 2006.

This set of standards replaced the former seven generic areas of work for the anti-fraud provision and they encompass a mandatory annual Quality Assurance process which is centred on the following key areas:

- **Strategic Governance –** This sets out the standards in relation to the organisations strategic governance arrangements. The aim is to ensure that fraud preventative measures are embedded at all levels across the organisation.

- **Inform and Involve –** This sets out the requirements into raising awareness of crime risks against the NHS and working with NHS staff, stakeholders and the public to highlight the risks and consequences of crime against the NHS.

- **Prevent and Deter –** This sets out the requirements in relation to discouraging individuals who may be tempted to commit crimes against the NHS and ensuring that opportunities for crime to occur are minimised.

- **Hold to Account –** This sets out the requirements in relation to detecting and investigating crime, prosecuting those who have committed crimes and seeking redress.

During 2020, the ABUHB Counter Fraud provision was subject of an in-depth assessment by Audit Wales, as part of an all-Wales review. The AW report was positive and the ABUHB Team immerged well in comparison to counterparts in other Health Boards. This AW report was delivered to Audit Committee in October 2020.

As of April 2021, the Government Functional Standard for Counter Fraud (GovS 013) replaces the previous NHS specific Standards for Fraud, Bribery and Corruption. Together with stakeholders the NHSCFA have developed new NHS Requirements to meet the Government Functional Standards. These changes are reflected in the ABUHB Counter Fraud Bribery & Corruption Workplan for 2021/21.

The NHSCFA have initiated changes to the investigation case management system called '*First'* (Fraud Information Reporting System Toolkit). This is a restricted and confidential system which has been used by the LCFS in the region of 15-years. *'First'* is being replaced by *'Clue-3'* which has the capacity for integration with the Police and other domains of law enforcement. The ABUHB LCFS's have undergone training on the replacement system which is anticipated to be rolled out by 1st April 2021. Due to technical complications, it is not envisaged that existing active investigations on '*First'* will be migrated over to *'Clue-3'* but both systems will have to be used in tandem until the cases on *'First'* reach their conclusion and are closed on *'First'*.

2.2 The LCFS has maintained an ongoing review of the following policies/protocols initially incepted in 2011, which are pertinent to Counter Fraud to ensure that they remain current, effective, up to date and fit for purpose.

- Counter Fraud Bribery & Corruption Policy
- Counter Fraud Communication Strategy
- Local Counter Fraud Specialist & Workforce & OD Joint Working Protocol
- Policy entitled Appearing in Court
- Counter Fraud protocol with Internal Audit

2.3 The Counter Fraud Bribery & Corruption Policy was updated in 2020, prior to its renewal date in June 2020. The Communication Strategy was updated in March

2021. All policies received Executive approval and that of the Workforce & OD Policy Group.

2.4 Furthermore, the LCFS has engaged with the Board Secretary regarding the ABUHB Standards of Business Conduct for Employees Policy. The organisation will ensure that there is evidence of compliance through outcomes. The effectiveness of the work will be evaluated as will the reduction of the risk. The awareness of the policy amongst staff has also been tested.

2.5 Since April 2011, the LCFS has acted in a consultation role to the Workforce and OD Policy Group and has received notification of all policies, terms of reference guidance notes that are subject of review by the group. This ensures that the policies are robust and 'Fraud Proofed' at concept stage. Further information is provided on this topic at paragraph 4.24 regarding the **fifteen (15)** policies reviewed by the LCFS during 2020/21.

2.6 With reference to the aforementioned policy entitled 'Appearing in Court' the ABUHB LCFS continued to distribute a self-designed tri-fold leaflet on this theme, which can be provided to members of ABUHB staff in the event that they become a Crown witness in a prosecution case.

The information contained in the tri-fold leaflet has been promoted on Counter Fraud webpages.

A single point of contact within the organisation has been nominated to provide support and wellbeing service to such staff members, which could also include providing a chaperon to court.

Evidence of recognition and appreciation of staff who are prepared to make the commitment and become crown witnesses is reflected in investigation **seventeen (17)** on **Appendix 2**. In this instance, members of NHS staff including Directorate Managers and three very senior clinicians were prepared to stand up and be counted and do the right thing and become Crown witnesses in an extremely difficult case.

2.7 The Board of ABUHB has ensured that the resources invested into counter fraud work are appropriate to counter fraud, bribery and corruption. The Counter Fraud staffing level has been maintained at 2.8 WTE which will have a marked impact on the Counter Fraud provision for 2021/22.

2.8 This is evidence that there is strong political and executive support for work to counter fraud, bribery and corruption and that the organisation is committed to making financial investment in work to tackle fraud, bribery and corruption which is proportionate to identified risks.

2.9 The budgetary provisions of ABUHB is contingent for the purchase of Counter Fraud promotional memorabilia. These products, which feature under the inform and involve domain, include 'give away' products at presentations such as post-it pads, keyrings, pens etc, liveried with LCFS corporate identity and contact information. Distribution of such products serves to raise the awareness of the workforce, make them fraud savvy and encourage them to report suspicions of fraudulent activity.

2.10 To supplement previously purchased presentation display boards and the Fraud Criminal Law & Procedure Manual, these 'give away' products are duly replenished by ABUHB as required. This displays further evidence of financial investment on behalf of the ABUHB Board towards tackling fraud, bribery and

corruption in the NHS. The LCFS has negotiated further replenishing of the products on a rolling basis.

2.11 This also demonstrates that the Board has a clear remit to reducing losses to fraud and corruption to an absolute minimum by the appropriate application of counter fraud resources. The Counter Fraud staffing level of 2.8 WTE LCFS' remains incorporated in the LHB formal organisational structure.

2.12 ABUHB has taken steps to ensure that the resources invested into Counter Fraud work are appropriate to counter fraud. The number of days invested to counter fraud work was based on the relevant NHSCFA template workplan but was also bespoke to the organisational needs. The LHB has taken steps to ensure there is a clear counter fraud strategy and remit present within the organisation.

A balanced and comprehensive workplan was agreed by the Director of Finance for the LHB. The plan was dynamic and reflective of the needs of the organisation.

2.13 The plan covered all the counter fraud bribery and corruption standards and relevant anti-fraud measures to ensure that a comprehensive service was provided. The plan also incorporated amendments made to the standards.

2.14 Tasks were allocated with consideration of local fraud risks and were flexible in order to accommodate changes.

The plan outlined a balance of both proactive and reactive work to address fraud issues. The workplan was approved by the Director of Finance and ratified by Audit Committee and progress against the plan is monitored accordingly.

2.15 On a reporting perspective, the LCFS customarily has bi-monthly meetings scheduled with the DoF to appraise and update on Counter Fraud work and identify and manage risk. The LCFS met with the DoF in this capacity on the following dates: 28/04/20, 21/07/20, 20/10/20, 28/01/21 & 02/02/21. These meetings were supplemented by telephone and email contact maintained with the DoF, to whom, the LCFS has unrestricted access.

2.16 Furthermore, to consolidate the reporting process, the LCFS met with the Interim Medical Director on 05/05/20, with further interactions taking place during May & June 2020, as investigation **(17)** on **Appendix 2** demanded such.

2.17 Considerations have also been made as to how identified or perceived risks are covered off and alerted organisation-wide and how this information is disseminated down through the structures within various divisions to reach staff of all grades. The aim is to establish mechanisms to cascade the information to a wider managerial audience and encourage more managers to become proactive in relation to recognising counter fraud risks. This will mitigate the risks even further.

2.18 The LCFS has achieved a more effective communication flow process via the Assistant Director of Finance (Corporate) who, on behalf of the LCFS, highlights areas of concern at senior management team meetings, hosted by the Chief Operating Officer/Deputy CEO for cascade down through the organisations divisional structures.

2.19 Additionally, Counter Fraud reporting is a standing agenda item for the Audit Committee meetings. In compliance with Legal Directions, the LCFS attended and delivered reports to 3 Audit Committees on 2nd April 2020, 22nd October

2020 & 4th February 2021. The LCFS also holds meetings to report to Audit Wales as and when required. The most recent engagement between the LCFS and AW Officers was on 28th August 2020.

2.20 All aspects of Counter Fraud strategic governance is incorporated in the Audit Committee Self-Assessment Checklist. There is a requirement that as part of compliance and professional probity, the LCFS has a right of direct access to the Audit Committee Chair and its independent members. This entails private, pre-Audit Committee meetings with said members. The LCFS held such private meetings on 24/09/20, 04/02/21 & 08/02/21.

2.21 With reference to further reporting, as part of quality assurance requirements the LCFS submitted the self-review report based on the Standards for NHS Bodies (Wales) to NHSCFA on 23rd March 2020.

2.22 In order to retain core skills and maintain best practice, the LCFS's have kept up to date on legislation and working practices through attendance at various training sessions. As part of continuing professional development, these inputs included training sessions from the NHSCFA. These sessions are more fully outlined in para 6.6 of this report.

2.23 Additionally, all three ABUHB LCFS's were attendees of the National Public Sector Counter Fraud Summit on 23rd February 2021.

2.24 Furthermore, the LCFS attended the All Wales LCFS Forums on 15/10/20, 18/11/20, 02/02/21 & 15/03/21 respectively.

3 Inform & Involve

3.1 The Health Board has worked with the LCFS and NHSCFA to promote an anti-fraud culture within the NHS. The LCFS's and Director of Finance (DoF), identified target audiences for fraud awareness activities, with the following objectives:

- To highlight the role of LHB staff/contractors in the tackling of fraud, bribery and corruption within the LHB/NHS.
- To deliver a key message that fraud within the NHS is unacceptable, indefensible and will not be tolerated.
- To deter attendees from committing fraud against the NHS.
- To encourage individuals to report any concerns of fraud.

3.2 The fraud awareness programme undertaken by the LCFS is reaching its target audience and all mediums are being exploited in order to actively promote & encourage fraud referrals.

In ABUHB, for PADR purposes, Counter Fraud awareness input at Corporate Induction and the fraud awareness e-learning programmes remain mandatory requirements.

Quarter 3 Counter Fraud performance statistics for 2020/21, indicate that ABUHB continues to have the highest staff uptake figure of all 7-NHS Health Boards in Wales for Counter Fraud e-Learning with 2,974 staff having completed the programme.

Prior to Covid lockdown, the Counter Fraud Service performance report illustrated that ABUHB had delivered the second highest number of fraud awareness presentations to the Corporate Induction programme of the 7-Health

Boards in Wales. Quarter 3 stats for 2020/21 demonstrate that ABUHB is still amongst the national leaders in this realm.

The Corporate Induction programme in ABUHB was suspended upon Covid lockdown in March 2020.

On the aspect of staff fraud awareness training, such training is a standing agenda item on every staff Corporate Induction in ABUHB. Whereas this training is normally delivered in person, to adapt during Covid restrictions, Counter Fraud have made a 45-minute video film of the training to provide virtual staff training until it is safe to resume conventional classroom training.

The video encompasses the film, 'taking the U out of fraud', it highlights NHS fraud risk areas, advises of the protection for staff under the Raising Concerns Policy with regard to whistleblowing and the video actively encourages the reporting of suspected fraud.

To comply with legal requirements, the video film is equipped with Welsh language sub-titles for viewers who wish to avail themselves of that facility. This fraud awareness video film went 'live' as part of virtual Corporate Induction at the beginning of November 2020. The staff uptake figures only identify staff numbers who complete the full Corporate Induction programme, not staff numbers who go through the programme over a period of time in a piecemeal fashion making multiple logon sessions. To-date, 175 members of staff completed the induction programme. During that same timeframe, the LCFS received 12-fraud referrals which is a further indication that the inform & involve strand of LCFS work is reaching its target audience.

3.3 To promote fraud awareness, in addition to attending every Corporate Induction session, the LCFS's would customarily attend major events such as the AGM, the annual HCA Conference and ABUHB careers fairs. In addition to this, Counter Fraud portable display stands would be sited at conspicuous locations in hospital environment's on a rotational basis. Covid lockdown curtailed these activities on the part of the LCFS, however; it is intended to resume these activities as soon as Covid restrictions permit.

3.4 During 2020/21, staff fraud awareness surveys were disseminated to the following Divisions:

Workforce & Organisational Development - 126 surveys sent out - 23 returned = 18.25% uptake rate.

- *26% had never attended a LCFS fraud awareness session.*
- *91% had seen publicity relating to fraud, bribery & corruption.*
- *48%% had completed* fraud *awareness eLearning.*
- *95.6% were aware that ABUHB had a fraud, bribery & corruption policy.*
- *82.6% knew how to report a fraud.*

Information Governance - responses received = 100% return rate.

- *10% had never attended a LCFS fraud awareness session.*
- *100% had seen publicity relating to fraud, bribery & corruption.*
- *80%% had completed fraud awareness eLearning.*
- *80% were aware that ABUHB had a fraud, bribery & corruption policy.*
- *100% knew how to report a fraud.*

These are very positive responses which indicate a strong anti-fraud, bribery and corruption culture where fraudulent and corrupt activity is not tolerated and all staff are aware of their responsibility to safeguard the NHS from economic crime, as well as recognizing the correct reporting procedures. A

strong counter fraud, bribery and corruption culture provides the organisation with assurance that fraud will be recognized and reported.

With the support of the Senior Education & Development Manager, the LCFS is currently initiating electronic staff surveys via Smart Survey. This medium is anticipated to generate a greater survey uptake response and reach a wider target audience.

3.5 Further assurance that the Fraud awareness programme undertaken by the LCFS is reaching its target audience is typified in the schedule of investigations in **Appendix 2** and the 'whistleblowing' attributed to the majority of these investigations. This displays support for the work of the LCFS and support of the anti-fraud culture promoted by the ABUHB organisation.

Examples of this are investigations listed as **(2)(12)(16)(22)(28)(34) & (35)** which stemmed from the 0800 National Fraud & Corruption Reporting Line. The remainder of the investigations on **Appendix 2,** were predominantly paper based anonymous fraud referrals using referral forms downloaded from the ABUHB Counter Fraud Team web-pages. This is a clear indication that all mediums are being used by 'whistleblowers' to report suspicions of fraud. The NHSCFA on-line reporting tool is also promoted by the LCFS but no referrals have been received via this medium.

Additionally, under case reference WARO/18/00082 the Counter Fraud Service Wales were referred a General Ophthalmic Services investigation by the ABUHB LCFS. This case remains an ongoing investigation and again highlights the promotional work undertaken by the ABUHB LCFS.

3.6 In addition to paragraph 3.7 above, the sheer volume of referrals received by the ABUHB LCFS is testament that the anti-fraud message is getting across and hitting the intended target audience.

3.7 The LCFS has actively promoted CFS Wales, NHSCFA and the 0800 National Fraud & Corruption Reporting Line and online reporting tool and this is prominent in the Counter Fraud Bribery & Corruption Policy, the Standards of Business conduct for Employees, the Fraud e-learning application and Corporate Finance budget e-learning application, in addition to presentation material.

3.8 On an all Wales basis, ABUHB personnel have consistently rated as amongst the top scoring of all NHS in Wales for having completed the fraud awareness e-learning application. This positive response has been enhanced by the fact that the fraud awareness e-learning application is a mandatory training dimension on ESR PADR for all ABUHB staff. The most recently available e-learning uptake figures for quarter 3 of 2020/21, which indicates 2,974 members of staff have completed the application which equates to 22.22% of the workforce. This is currently the highest uptake figure in Wales. The LCFS is now endeavouring to consolidate this figure following the placement of a reminder of this PADR mandatory learning requirement on the carousel on the ABUHB intranet homepage during March 2021.

3.9 Fraud Awareness month (FAM) which was a national NHS initiative was customarily orchestrated/managed by NHSCFA. This initiative has been reinitiated by the NHS Counter Fraud Service, following a number of year's absence due to funding restrictions. This initiative not only serves to create an anti-fraud culture but heightens the awareness of a high footfall number of employees of all grades and the general public alike. The ABUHB is a participant in FAM, which will resume as soon as Covid restrictions permit.

3.10 Fraud information has been updated on the Aneurin Bevan University Health Board intranet website, which has advertised the outcomes of investigations and guidelines to staff for reporting fraud in addition to fraud notices. The ABUHB website was regularly updated and the LCFS web-pages and ancillary platforms received 983 'hits' during 2020/21. Articles placed on the organisation's intranet site front page comprised of national press releases, local sanctions and general fraud awareness messages from the LCFS. The LCFS has maintained the implementation on the ABUHB website the video entitled 'Taking the U out of Fraud' on the aforementioned web-pages. The format of the web-pages has been amended to meet corporate design.

3.11 In addition to the Counter Fraud's own section of the website, the LCFS is implementing a link tab on the ABUHB intranet homepage which provides direct access to the Counter Fraud referral form. This is with a view to encouraging users of the intranet to make Counter Fraud referrals.

There is a further link on this site for the Counter Fraud Bribery & Corruption Policy to heighten the awareness of the workforce in this realm.

3.12 A Counter Fraud newsletter was distributed to LHB Primary Care Contractors during 2020/21 with various counter fraud articles and successful NHS fraud cases. In total there are 383 Primary Care Contractors that provide NHS services to ABUHB which consist of GP's, Optometrists, Dentists and Pharmacists. The newsletter promotes the NHS Fraud and Corruption Reporting Line and LCFS contact details. The newsletter is bespoke and topical for primary care contractors.

3.13 A staff orientated Counter Fraud Newsletter was also publicized on the ABUHB intranet during 2020/21 and was accessible to the entire workforce.

3.14 The corporate identity and contact details of the LCFS is also incorporated in the Local Intelligence Network (LIN) newsletter which is accessible to the workforce of ABUHB and which is disseminated to all GP Practices and Community Pharmacies within the LHB.

3.15 The LCFS has set up a network of contacts throughout Aneurin Bevan University Health Board to enable an effective counter fraud programme. This includes Workforce & OD, Internal Audit, Procurement and Security and the PPV, Payroll and Primary Care Service Contracts Teams of NWSSP.

3.16 The LCFS has also established contacts and working relationships with the Department of Works and Pensions Regional Fraud Team, Council Fraud Team and the Police.

3.17 The LCFS has established a direct contact within the UK Borders Agency & H.M. Passport Office. This relationship has involved the sharing of information to progress investigations undertaken by both organisations.

Additionally, the LCFS has formulated links between UKBA and ABUHB Medical Recruitment to enhance the collaboration as to the employment and residency status of overseas visitors and identity checks.

3.18 Further evidence of partnership working are cases **(17)(24)(25)(26)** & **(43)** on **Appendix 2** which resulted in gateway taxation requests being made by the LCFS to HMR&C.

3.19 The LCFS has initiated Counter Fraud awareness messages to be sent to every member of staff employed by the LHB by placing an entry on all employees'

payslips highlighting the criminal liability of the willful retention of a salary overpayment.

3.20 In addition to the above, the LCFS has provided Payroll Services with a list of ten Counter Fraud awareness messages which are published on staff payslips on a rolling programme as and when free space allows.

For the most-part, these messages generally contain an encouragement theme to report fraud, for example 'Spot it – Stop it'. Two other recurring payslip messages warn against working elsewhere whilst on sick leave and the dishonest retention of erroneous salary overpayments.

4 Prevent & Deter

4.1 The LCFS is responsible for taking steps to prevent fraud against the LHB by eliminating system weaknesses to reduce the risk of fraud.

4.2 In order to ensure that they remain current, effective and up-to-date, the LCFS has a rolling-programme for reviewing the following polices/protocols which were initially created in 2011. These policies were extensively revamped again during 2014/15. This is necessary in order to reinforce the infrastructure of directives and the framework of organisation guidelines necessary to support the Counter Fraud provision. The Counter fraud Bribery & Corruption Policy was last updated in 2020 ahead of its renewal date of June 2020. The policy was published on the ABUHB intranet and was highlighted in Nye's News during 2020, which was circulated across the organisation. Similarly, the Communication Strategy was updated in March 2021. All policies received Executive approval and Workforce & OD Policy Group input where necessary. These policies continue to be reviewed in compliance with target dates to ensure they are maintained up-to-date and fit for purpose. The LCFS has recently referred the Appearing in Court Policy to the Legal Services Directorate for updating.

- Counter Fraud Bribery & Corruption Policy
- Counter Fraud Communication Strategy
- LCFS & Workforce & OD Joint Working Protocol
- Policy entitled Appearing in Court
- Counter Fraud Protocol with Internal Audit

4.3 The LCFS has worked proactively with the NHS Wales Shared Services Partnership-Primary Care Services GOS Payments Officers and the Ophthalmic Adviser. All General Ophthalmic Service payments made to Contractors are monitored and the LCFS is provided with quarterly GOS trend data for all ABUHB GOS contractors. This data is scrutinized for abnormalities in claiming patterns. Such analysis has resulted in an investigation being referred to CFS Wales by the ABUHB LCFS under WARO/18/00082 and this remains a live investigation.

In addition to the above, on a contractor by contractor basis, the LCFS receives every GMS and GOS visit report which incorporates recoveries made.

4.4 The LCFS is linked to the Audit Committee via the DoF. The Audit Committee reviews the adequacy of the structures, processes and responsibilities for identifying and managing key financial risks facing the LHB.

The LCFS attends Audit Committees to highlight fraud risks and to appraise the Committee of current work undertaken by the Counter Fraud Team. The Counter Fraud update report and LCFS attendance at the Audit Committee is a standing agenda item on Audit Committee agendas.

4.5 The LCFS has developed relationships with individuals whose role within the LHB has an impact on counter fraud work to identify local areas of risk. The LCFS also meets regularly with External Organisations such as the Police, NWSSP-Primary Care Services, UK Borders Agency and the Department for Work and Pensions (DWP) to gather intelligence and identify Local and National risks. The LCFS also engages with HMR&C in this capacity and also engages with the Counter Fraud Operations Team of the H.M. Passport Office.

4.6 During 2020/21, as part of working in partnership with the Police, the ABUHB LCFS has provided criminal intelligence reports to the Gwent Police Force Intelligence Bureau on **three (3)** occasions, whereby the information would be deemed to be of value to law enforcement. In addition to this, the LCFS has also disseminated intelligence reports to the Police Regional Asset Recovery Team and the Central Intelligence Unit of NHSCFA on **four (4)** occasions. The LCFS routinely provides NHS Drug Alerts to the Gwent Police Pharmacy Manager and works in close collaboration with that Manager. Conversely, this information sharing practice has resulted in the LCFS being afforded access to Police held intelligence which was pertinent to the NHS.

Further evidence of partnership working with the Police are investigations **(8) & (11)** on **Appendix 2,** which are collaborative investigations. In relation to investigation **(11)** the LCFS enlisted Police support to arrest the suspect and joint LCFS/Police interviews under caution resulted as a consequence. This culminated in a joint LCFS/Police prosecution via the CPS.

4.7 The LCFS also liaises regularly with the PPV Team and all PPV reports which form part of the standing agenda item at Audit Committee are disseminated to the LCFS. Any concerns of fraud highlighted at a PPV visit are discussed immediately with the LCFS and the appropriate action is agreed. The PPV team reports their findings directly to the DoF. The LCFS has input to a current project conducted by NWSSP-PCS PPV in relation to data set trend analysis in the General Ophthalmic Services domain designed to identify inappropriate claiming in that primary care arena.

4.8 NWSSP-Primary Care Services is responsible for registering all new patients at GP Practices in Wales. Any patients that register with another practice will automatically be removed from the patient list of their previous practice. If a person fraudulently attempts to register at a practice temporarily to obtain prescription medication or controlled drugs an alert is sent out to all GP practices in the area. The LCFS receives every drug alert that is circulated and these alerts customarily highlight prescription fraud and cases of multiple fraudulent patient registration at GP Practices.

4.9 Routinely, the ABUHB LCFS has utilized the NWSSP-PCS Contracts Team drug alert system to generate the LCFS's own drug alerts which contain information and intelligence which has come to the attention of the LCFS via a variety of sources. These drug alerts can be circulated throughout an individual Health Board or clustered to a number of Health Boards or throughout all HB's in Wales if deemed necessary. The alerts are disseminated to prescribers, or dispensers or both if required.

Additionally, on **five (5)** occasions during 2020/21 the LCFS has utilized ABUHB Primary Care Team resources to alert all Gwent GP Practices of immerging fraud threats which targeted the primary care GMS domain.

4.10 Fraud prevention circulars can be issued by NHSCFA under the WG directions for Countering Fraud. Any such circulars include the request for specific action to highlight and minimize any known fraud risk. These fraud prevention

instructions referred to as IBURN emanate from the Central Intelligence Unit (CIU) of NHSCFA. During 2020/21 the LCFS has actioned **two (2)** such circulars relating to recruitment fraud and payment diversion fraud.

4.11 In light In light of the COVID-19 crisis, all the indicators from the WG, the Government Counter Fraud Function and the NHS Counter Fraud Authority is that fraud risks are currently high and the economic attack against the NHS and other public sector bodies will increase.

The principal threat remains at Procurement level, i.e. banking mandate fraud, invoice fraud and the offer of goods or services which do not exist. During Covid lockdown, dubious offers of supplies of PPE have been received. A further example is offering the supply of 45 CE Marked ICU appropriate Ventilators for treatment of Covid19. Fraudulent invoices have also been received. Internal financial controls have been effective and have prevented these aspects to date.

Due to the threat level, the ABUHB LCFS has continued to focus on banking mandate and invoice fraud in the Procurement Services domain. During 2020/21, nationally within the NHS, banking mandate fraud has remained a high risk fraud threat and ABUHB has been subject to attack from this type of high risk/high value fraud.

This fraud occurs when fraudsters implement changes to the banking mandate details of legitimate external suppliers/service providers, on Oracle via NHS Procurement Services (Accounts Payable) to that of the fraudsters own bank accounts. Outgoing payments are then hijacked into the fraudsters' bank accounts.

The ABUHB LCFS reviewed and risk assessed preventative measures which had been implemented a number of years previously to discover that due to a reconfiguration of duties within NWSSP, the measures may have become diminished and weakened.

The LCFS is scheduled to address the full ABUHB Procurement Team on 25th March 2021, when the following directives will be reinforced to mitigate this area of fraud:

- No banking mandate changes will be implemented on the basis of an incoming telephone call or the receipt of an email or letter alone.

- To confirm the authenticity of the banking mandate request, the requesting supplier/service provider should be contacted (not on the contact reference on the letter but on the verified and established contact details NHS have held for them historically on file).

- A contact who is known to the NHS from within the company (with whom NHS have engaged previously) should be spoken with to and confirm the authenticity of the banking mandate request.

- To mitigate the insider threat, the NWSSP staff member who implements banking mandate changes should not be authorised to process payments on Oracle etc. This means that it would require two members of staff to collude or conspire together to transfer payments to a fraudulent bank account.

The aforementioned action comes in the light of a successful fraudulent standard mandate BACS change in one of the neighbouring Welsh HB's, which involved the use of an NHS Wales form.

Fraudsters diverted around £80k but the Counter Fraud Service Wales Team have managed to restrain £60k of that loss.

This demonstrates that the threat to the NHS is ever present from this type of fraud and there is a real need for continued and heightened vigilance on the part of Procurement Services and Corporate Finance staff.

4.12 An area of newly managed risk within Procurement Services follows arrangements to support supplier businesses during Covid which was highlighted by the Cabinet Office in March 2020. NHS Wales moved to support businesses during Covid with the aim of paying suppliers more speedily, improving their cash flow. This was the catalyst to a variation in the 3-tier procurement protocol for the payment of invoices under £500.00 in value. These type of invoices are of low individual value but extremely high in volume.

In its simplest form, the 3-tier system is:
1) ORDER.
2) INVOICE.
3) CONFIRM RECEIPT OF GOODS.
Then payment is made.

The change in protocol was that receipted verification would be undertaken retrospectively following payment.

Potential risks associated with the change of protocol are:
Being invoiced for goods/services not supplied.
The potential for invoice splitting by supplier on higher value transactions to keep invoice values below the £500.00 threshold.

The LCFS has confirmed with Procurement Services that retrospective receipted verification is being carried out and that spot checks have been done on samples of invoices which have been paid without being receipted and very few issues or areas of concern have been identified.

4.13 As with every NHS Healthcare organisation, ABUHB remains under sustained attack from cyber fraud. This predominately relates to attempts of banking mandate fraud, contractor invoice fraud and attempts to illicit same day electronic money transfers.

All preventative measures and internal financial controls have defeated these attempts at fraud and remain effective. The fraudsters have become increasingly accomplished at cloning e-mail addresses of ABUHB personnel which are regularly utilized in their fraudulent efforts.

The LCFS has continued working in conjunction with NWIS who have applied system filters with a view to intercepting these cyber fraud attacks prior to them reaching their intended targets. This includes the blacklisting of identified I.P. addresses used by the fraudsters.

4.14 During the Covid pandemic, fraudsters have continued to target NHS staff as part of salary diversion fraud and attempts to implement password changes to e-expenses but this again, has been unsuccessful.

Scammers purporting to be HMR&C initially targeted all NHS staff but then focused on returnees to the NHS, who may be more susceptible to communication from HMR&C due to their changing taxation status. Measures have been implemented to mitigate this.

4.15 During 2020/21, the ABUHB LCFS responded to **six (6)** fraud prevention notices from NHSCFA and executed and actioned them accordingly. The themes of these FPN's were:

- Procurement - supplier fraud
- Credit card management
- Mortality screening
- Continence services – product fraud
- Banking mandate fraud

4.16 Additionally, the ABUHB LCFS generated a further **five (5)** self-initiated alerts on banking mandate fraud throughout the Corporate Finance and Procurement communities.

4.17 The LCFS risk assessed cash income reconciliation within Charitable Funds. (Confirmation made that completed receipt books are being returned to Charitable Funds and that secondary reconciliation is being undertaken). The Charitable Funds Policy has been reviewed by LCFS and it reflects these best practice arrangements).

As a consequence of actions raised at Audit Committee on 22nd October 2020, in relation to non-cash flow donations to Charitable Funds, the LCFS has conducted an exercise in this domain in collaboration with the Charitable Funds Team. This exercise analysed all donations on a Health Board site by site basis against donation type (cash, cheque, direct bank payment and credit card). The exercise identified that two sites had 100% cheque donations (Mamhilad & Serrennu) and two sites had 100% cash donations (Monmouth & St Cadocs) whereas the remainder of the sites have a combination of both. This initially appeared to be an outlier but was satisfactorily explained during the course of the exercise.

The exercise identified the following factors which are likely to have had some influence over the changes to the methods and amounts of donations during the past 2-years.

- Serrenu site is now included with St Woolos donations and Serrenu banking is amalgamated accordingly. This is due to that fact that Serrenu is a low generator of ABUHB donations, probably as a consequence of the Sparkle Charity operating from this site. Consequently most donations are likely to go to that source.
- St Cadocs site - historically does not generate high donations (customarily cash) from the Woodshed project and small amounts of re-banked monies.
- Monmouth site - has a strong League of Friends presence, who are pro-active on site for the hospital so consequently most donations go to that source as opposed to ABUHB. This explains the small amount of cash received in 2019/20.

Due to the impact of the Covid-19 pandemic, the past year has seen a reduction in the number of visitors to ABUHB hospital sites, consequently cash and cheque donations have been impacted upon and are much lower than previous years, a theme noted across all sites.

A Just Giving Page was created at the onset of the pandemic and this has led to a marked increase in the number of donations being made via this medium, in 19/20 £8,277.69 (1.21% of all donations) was donated compared to £181,081.81 (21.15% of all donations) in 20/21. At the time of this exercise,

despite cash & cheque donations being significantly reduced, banked income has increased by circa 25%.

Additional grants for Covid-19 in 20/21 has also resulted in additional funds.

During the Covid pandemic, the Charitable Funds Team have been restricted from personal visits to hospital wards in order to remind staff about Charitable Funds procedures, along with the need to bank donations in a timely fashion. The team have also been curtailed from undertaking the necessary checks of the receipt books against the ledger entries. However; the ABUHB Counter Fraud Team consider that there has been good compliance with staff adhering to the financial controls already in place regarding donations etc.

To address the lack of face to face inputs the Charitable Funds Department is currently considering alternative methods to address this issue for example sending a generic e-mail to relevant staff, highlighting key points and procedures. In addition, the team is formulating a training package to be delivered via the Teams platform by the end of this financial year to those staff identified with the responsibility for dealing with charitable funds in their designated work area.

These findings have been shared with Internal Audit and the full data will be made available to Audit Committee if required.

4.18 In addition to the aforementioned exercise, the LCFS has conducted further risk assessments as follows:

- Cash income handling and reconciliation for managed G.P. Practices. (Receipts must accompany income register sheets to the Treasury Management Team).
- Pre-employment and reference checks for applicants for inclusion on Welsh G.P. Performers List (pre-employment checks must be undertaken for each applicant).

4.19 The LCFS has disseminated scam alerts to the workforce on various issues when cybercrime was targeted at staff members. These alerts were generated by HMR&C, Police and NHSCFA.

4.20 During all engagement with G.P. Practices, the LCFS highlights themes of concern which stem from information governance failures in internal controls which could create a platform for manipulation of the patient management systems.

Potential system weaknesses highlighted are:

- All staff using open terminals on one password logon.
- Central record kept of all staff members system passwords and usernames (including GP's).
- Staff members registered as patients at practice.
- Staff members registered on patient management system at Practice as temporary residents.
- Staff members having patient management system capacity to generate prescriptions for family members.

The LCFS advice extends to safeguards against patient multiple registration fraud and the necessity for photographic identification to be produced and copied/retained by the surgery on each and every patient registration.

4.21 The LCFS is a permanent attendee of the Gwent Local Intelligence Network (LIN). The Medical Director is the Accountable Officer for the LIN which has Police representation, representation from neighboring county LIN's and also representation from HoPMM, Pharmacy, GPhC, Health Inspectorate Wales, Care & Social Services Inspectorate Wales and this allows for exchanges of information. A primary function of the LIN relates to the security of and addressing risk factors attached to controlled drugs (CD's).

The LCFS was scheduled to attend all LIN meetings during year 2020/21, however; the meetings were suspended due to Covid restrictions. The LCFS will resume this attendance as soon as Covid restrictions permit.

As a by-product of the LIN, the LCFS is named (with contact details) on the LIN Newsletters and this serves to promote the identity of the LCFS and highlight their presence to the workforce and all GP's and Community Pharmacists within the LHB.

4.22 Additionally, the LCFS was a fully appointed member of the NHS Prescription and Forms Group (Wales). This group had the capacity to implement changes to prescription forms and NHS forms in Wales. Security issues relating to NHS forms and prescription form handling were addressed by the Group which also has Welsh Government (WG) representation. The group has been dissolved however, the LCFS would continue to be consulted prior to any major changes in prescription and NHS forms in Wales.

4.23 The LCFS monitors the pharmacy reward scheme within the LHB and is the sole countersignatory to authorise payments under the scheme. The LCFS liaises with Pharmacist and G.P. primary care contractors to ensure the guidelines are adhered to and that prescription fraud is reported appropriately.

The LCFS has also provided these contractors with written literature relating to the pharmacy reward rules to heighten their awareness to prescription fraud.

These rules have been distributed to all 130 Pharmacies in the LHB. During year 2020/21 ABUHB have made payment on **three (3)** Pharmacy Reward Scheme claims.

The previously mentioned Counter Fraud Newsletter, disseminated by the LCFS to all 130 Community Pharmacies within ABUHB reinforced the Pharmacy Reward Scheme.

4.24 Since April 2011, the LCFS has acted in a consultancy role to the Workforce & OD Policy Group and has received notification of all polices, terms of reference guidance notes that are subject of review by the group. This ensures that all policies are robust and 'Fraud Proofed' at concept stage.

The LCFS has reviewed and has initiated inclusions on **fifteen (15)** documents which have been implemented by ABUHB during 2020/21. These policies are:-

- Appearing in Court Policy (referred by LCFS to Legal Services for renewal)
- PADR Process policy
- Management of Contractors Policy
- Preceptorship Policy
- HPC Registration and Checking Policy
- Roster Policy
- Self-administration Med in rehab patients
- Medication Administration
- Domestic Abuse & Sexual Violence - policy for supporting employees

- Bilingual Skills Strategy
- Welsh Language & Primary Care Policy
- Welsh Language skills requirement policy
- Welsh Language learning & development strategy
- Smoke Free Environment Policy
- Information Systems access control policy

4.25 A recurring issue within ABUHB is the overpayment of salaries and this is reflected in the schedule of investigations at **Appendix 2**. These overpayments occur when a member of staff erroneously continues to be paid full salary after they have reduced their working hours or after they have terminated employment with the Health Board completely.

The LCFS works in close liaison with the Accounts Receivable Team of Corporate Finance who informs the LCFS of each and every such overpayment. The LCFS is selective and identifies any suspected criminal conduct attached to the overpayments. If criminal conduct is apparent then a criminal investigation is incepted by the LCFS. If not, and the overpayment bears all the hallmarks of a civil debt, then the Accounts Receivable Team seek to recover the debt by an alternative civil legal process.

These overpayments arise as a consequence of one of two eventualities prevailing: (1) ABUHB Managers fail to submit staff changes and staff termination forms in the appropriate manner (2) NWSSP Payroll Services fail to action staff change/termination forms when the forms have actually been submitted.

This problem is not unique to ABUHB. From collaboration with counterparts in other Welsh Health Boards, it is evident to the LCFS that this is an all-Wales issue.

The LCFS has maintained a proactive role to highlight these issues to the workforce by means of a variety of mediums.

Advice to ABUHB Managers has been reiterated on the intranet during March 2021, reminding Managers of their professional duty to submit staff change/termination forms in an expeditious and timely manner. This has previously been reinforced by a payslip message sent to all employees informing them that the willful retention of and failure to disclose an erroneous overpayment is likely to constitute a criminal offence of fraud by failing to disclose information. This staff message was also published on the ABUHB intranet.

The ABUHB LCFS also notifies their NWSSP counterpart of overpayments of salary, particularly when Payroll Services have failed to action notifications of staff changes/termination. The NWSSP LCFS reports these incidents to the DoF and Audit Committee of NWSSP with a view to improving operating systems and strengthening internal financial controls within Payroll Services.

4.26 A frequent concern raised by NHSCFA is potential relaxation of pre-employment checks in this time of Covid crisis and failure to comply with the NHS employment standards insomuch as the NHS may be employing staff as a consequence who have dubious or spurious credentials, or whose identity may not be verified as rigorously as usual. Pre-employment checks need to remain robust in this domain.

4.27 As required, the ABUHB LCFS engages with the Head of Engagement and Support for NWSSP on the aspect of monitoring and sharing of PPV audit data pertaining to claims by General Ophthalmic Service contractors.

Consequently, the LCFS has access to GOS trend data which allows for proactive monitoring of claiming patterns and for any abnormal claiming activity on the part of Health Board GOS contractors.

4.28 The LCFS frequently reports system weaknesses on the National Counter Fraud case management system 'FIRST' (Fraud Information Reporting System Toolkit) to allow for remedial national NHS system strengthening measures to be applied if considered necessary. This was the case in respect of the following investigations listed as on **Appendix 2**.

- **No: (13)** – Manager signing timesheets before shift concluded as located remotely from staff – change to process.
- **No: (25)** – Overpayment of Doctor, system flaw with medical recruitment. Now rectified by change in process.
- **No: (17)** – Directorate Managers allocating ad hoc backfill and WLI sessions without regard to contracted session commitments on job plan, change to process.
- **No: (33)** – Staff working outside core hours leaving department short staffed – change to process.

4.29 All Welsh HB Counter Fraud Teams have been required to participate in a thematic assessment governed by the NHSCFA. This was to ensure that financial regulatory controls were robust and effective.

The assessment focused on three specific domains in line with the Legal Standards for Health Bodies (Wales) which now replicate the Cabinet Office Standards:

- Pre-employment checks under standard 3.4
- Procurement fraud under standard 3.5
- Invoice fraud under standard 3.6

ABUHB immerged very well from the thematic assessment with the least stipulated corrective actions of all the Health Boards in Wales. The NHSCFA 2020 response to the ABUHB assessment contained three operational corrective findings, as follows:

In relation to pre-contract procurement fraud - the organisation should carry out local detailed risk assessment considering the NHSCFA guidance document. Risk assessments should be undertaken, recorded and managed in line with their risk management policies. Action plans should be developed to mitigate risks and progress should be reported on and submitted to the audit committee.

In relation to invoice fraud - the organisation should undertake a local detail risk assessment in line with the NHSCFA document, "Invoice fraud: Guidance for prevention and detection". Risk assessments should be recorded and managed in line with the organisations risk management policy. Actions required to mitigate any identified risks should be developed into an action plan and progress reported to the audit committee.

In relation to Procurement SFI's – the SFI should be reviewed and updated.

The response to the SFI aspect is the ABUHB procurement SFI has been updated by the AFD Corporate Finance and is an active control document which is fit for purpose.

With regard to the two further aforementioned corrective findings, the NHSCFA protocols on invoice fraud incorporates banking mandate fraud and supplier fraud. To ensure that internal financial controls are being implemented, the ABUHB LCFS developed risk assessment questionnaires in respect of these specified areas of risk and has collaborated with the Head of Procurement Services and Head of Internal Audit in respect of same. The response to the questionnaires was rapidly provided by the Head of Procurement Services. Risk assessment reports were compiled by the LCFS and presented to the Head of Procurement Services as the risk owner in this instance. The Head of Corporate Finance and Internal Audit were included in this process.

Conclusion on invoice fraud - the outcome of this analysis is that the likelihood of insider invoice fraud within the organisation scored low (green) – rating 1.5 and at this point in time is being adequately managed by existing policies and actions (temporary changes to these policies and procedures as a result of Covid Pandemic notwithstanding). This of course is contingent upon these procedures being followed.

The impact/consequence of fraud is this domain scored medium to high risk and should be considered as medium (amber) – rating 2.

Overall, using the residual risk scores rationale the result would be a score of 3 (green). This is an acceptable risk but should be reviewed on a regular basis due to the impact factors involved.

Recommendations on invoice fraud - cascading of relevant CFA guidance to relevant stakeholders and senior management as appropriate.

Well publicised and regular spot checks on whether policy and procedure and best practice is being followed in certain areas.

Conclusion on pre-contract procurement fraud - the outcome of this analysis is that the likelihood of pre-contract procurement fraud within the organisation scored low (green) – rating 2 and at this point in time is being adequately managed by existing policies and actions (temporary changes to these policies and procedures as a result of Covid Pandemic notwithstanding). This of course is contingent upon these procedures being followed.

The impact/consequence of fraud in this domain scored medium to high risk and should be considered as medium (amber) – rating 3.5.

Overall, using the residual risk scores rationale the result would be a score of 7 (green). This is an acceptable risk but should be reviewed on a regular basis due to the impact factors involved.

Recommendations on pre-contract fraud - cascading of relevant NHSCFA guidance to relevant stakeholders and senior management as appropriate.

Well publicised and regular spot checks on whether policy and procedure and best practice is being followed in certain areas e.g. scheme of delegation, conflicts of interest register, SFI's and contract splitting. This will serve to identify, detect and deter this type of fraud from taking place.

Conclusion on mandate fraud - the outcome of this analysis is that the likelihood of mandate fraud within the organisation scored low (green) – rating 1.5 and at this point in time is being adequately managed by existing policies and actions (temporary changes to these policies and procedures as a result of Covid Pandemic notwithstanding). This of course is contingent upon these procedures being followed.

The impact/consequence of fraud in this domain scored medium to high risk and should be considered as medium (amber) – rating 4.

Overall, using the residual risk scores rationale the result would be a score of 6 (green). This is an acceptable risk but should be reviewed on a regular basis due to the nature of the impact factors involved.

Recommendations on mandate fraud - cascading of relevant NHSCFA guidance to relevant stakeholders and senior management as appropriate.

Well publicised and regular spot checks on whether policy and procedure and best practice is being followed in certain areas.

Regular and ongoing training to all staff involved in this area to reaffirm best practice. Consideration to developing a training presentation in relation to mandate fraud to be cascaded to relevant stakeholders during the course of Covid pandemic whilst face to face training is not possible.

Further consideration/consultation given to what information is made public with regard to awarding of contracts.

Local proactive exercise in checking random suppliers for details on file at the Health Board.

Conclusion on supplier fraud - the outcome of this analysis is that the likelihood of supplier fraud within the organisation scored low (green) – rating 2 and at this point in time is being adequately managed by existing policies and actions (temporary changes to these policies and procedures as a result of Covid Pandemic notwithstanding). This of course is contingent upon these procedures being followed.

The impact/consequence of fraud is this domain scored medium to high risk and should be considered as medium (amber) – rating 3.5.

Overall, using the residual risk scores rationale the result would be a score of 7 (green). This is an acceptable risk but should be reviewed on a regular basis due to the impact factors involved.

Recommendation on supplier fraud - cascading of relevant NHSCFA guidance to relevant stakeholders and senior management as appropriate.

Well publicised and regular spot checks on whether policy and procedure and best practice is being followed in certain areas.

Adequate personnel given to reactive measures such as checking NFI trade creditor matches efficiently.

Checking of VAT numbers on invoices against known supplier details.

Spot checking of information on invoices against information already held by the Health Board.

These findings have been shared with Internal Audit and the full data will be made available to Audit Committee if required.

4.30 As a deterrent impact to staff working whilst on sick leave, the LCFS has made a second request to Workforce & OD that a question should be included in the return to work interview form which asks the member of staff if they have worked elsewhere during the period of sickness absence. This is to supplement information in the NHS Wales Managing Attendance at Work Policy which advises workforce of the potential disciplinary and criminal liability of this conduct. This request is currently being actioned.

4.31 In order to maximise the deterrence of fraud, the LCFS has promoted successful Local and National cases to LHB staff and Contractors at every given opportunity.

4.32 A range of communication tools have been utilised to deter staff and contractors from committing fraud, including: fraud awareness presentations, newsletters, leaflets/posters, payslip messages and Counter Fraud web pages and ABUHB intranet site & ESR homepage.

4.33 In relation to salary overpayments, a message to the workforce featured on the ABUHB intranet site advising of the criminal liability for prosecution under the Theft Act 1968 and Fraud Act 2006 of any person who knowingly retains a payment made to them in error. This message was supplemented as a payslip message.

4.34 During year 2020/21, the LCFS continued with the practice of naming individuals on the organisations website who have been successfully convicted of fraud at Court. The LCFS has also published depersonalized details of cases which resulted in staff being dismissed from the employment of ABUHB.

4.35 The LCFS has created a new platform on the Covid homepage of the ABUHB intranet to draw attention to immerging fraud threats during the Covid pandemic. The information on this platform supplements the Counter Fraud own webpages and the carousels on the ABUHB intranet homepage and the ESR homepage which have also been utilized by the LCFS. By means of these mediums and Facebook/twitter, the LCFS has published **thirty-six (36)** items during 2020/21.

The use of this deterrence method has been sustained by ABUHB and the LCFS as being legally permissible and proportionate under the circumstances and necessary to maximize the deterrence of fraud. This is in keeping with strategic framework of the Welsh Government for tackling fraud, bribery & corruption perpetrated against the NHS.

4.36 The LCFS has previously sought to exploit positive Counter Fraud reporting by utilizing media publicity in cases of fraud and corruption against the NHS to maximize deterrence against this type of conduct. This practice is ongoing.

4.37 The Counter Fraud Communication Strategy Policy developed for Aneurin Bevan University Health Board, outlines the communication methods that are utilized to promote fraud awareness.

4.38 The LCFS has continued to provide guidance to ABUHB Head of Communications that included the work of the NHS Counter Fraud Service (NHSCFA) Deterrence and Engagement Unit Media Team and the Advance Warning System adopted by that organisation. The DEU is able to support the LHB with media handling of cases that attract the attention of the press. The Head of Communications

was given advance notification of cases **(11)** & **(14)** on **Appendix 2**, prior to court hearings.

4.39 The Counter Fraud newsletters that were circulated during 2020/21, highlighted local and national cases of fraud against the NHS that have been successful in court. The newsletter also provided information on the correct way to report fraud and all the relevant contact details. The Newsletters sent out a clear deterrent message to readers that fraud in the NHS is unacceptable, indefensible and will not tolerated and that action will be taken against any known perpetrators.

4.40 The LCFS promotes the ABUHB Whistleblowing Policy in every instance at fraud awareness presentations and roadshows.

Feedback questionnaires are distributed at every presentation and the results of these questionnaires are retained and analysed by the LCFS. Any areas of perceived deficiency are addressed.

4.41 The proactive fraud detection exercise which was incepted by the LCFS in 2011 which centered on the audit of expenditure reports at ABUHB hospital Prescription Handling Directorates is still an ongoing rolling programme. This continuing audit of hospital prescription forms not only acts as a preventative measure but also acts as a deterrent because the LCFS publicizes the fact to prescribers that this scrutiny is taking place.

4.42 NHSCFA fraud prevention media titled, '*Who pays for fraud in the NHS – we all do'*, features on the ABUHB intranet site. This media encompasses current NHSCFA fraud prevention leaflets.

4.43 In conjunction with the Ward & Pharmacy Managers, following losses of medication from the Omnicel machines at A & E at Grange University Hospital, LCFS intervention implemented changes in January 2021, to the handling procedures in relation to Diazepam, Lorazepam, Co-codamol and Codeine tablets. These medicines now have the handling status of controlled drugs (despite the fact that they are not such) and a second witness is required to oversee their removal from the machine. This action curtailed the losses of those medicines to-date, however; as time progressed, it became necessary to extend this restriction to all drugs which are classified as drugs likely to misuse (DLM's). All incidents have been recorded on Datix.

4.44 Similarly, LCFS intervention has implemented changes to the handling procedures and storage of death certificates at the Grange University Hospital following the loss of two pads of certificates. These pads are now to be handled in the same fashion as prescription pads. The message promoted by the LCFS is that the pads should be handled akin to cash handling.

4.45 In order to ensure the effectiveness and staff awareness of the Standards of Business Conduct for Employees Policy, the Board Secretary continues to pursue the submission of declaration of interest forms or a nil return, whichever applies.

In order to reinforce the obligation for staff to submit declarations of interest, the aspect is included on ESR as part of PADR core documents in order to reach the largest audience of staff members.

5 Hold to Account

5.1 The LCFS has highlighted that a proactive review programme helps to develop the cultural change necessary to allow the Counter Fraud Strategy to be effective.

5.2 The Audit Commission is responsible for running the National Fraud Initiative (NFI). This commenced in 1996 and runs every two years. The NFI is an exercise that matches electronic data both within and between some 1,200 public sector bodies and participating private sector bodies to prevent and detect fraud. This includes the NHS, DWP, HMR&C, Police Authorities, Local Probation Boards, Fire and Rescue Authorities as well as Local Councils and number of private sector bodies. Since the NFI commenced, the initiative has helped to identify £1.93 billion of fraud, overpayment and error across UK public bodies. The NFI data collection operated in 2020/21. By the deadline date of October 2020, the LCFS facilitated the downloading of the Trade Creditors payment history and Trade Creditors standing data to the Wales Audit Office in compliance with the NFI mandate.

NHS Pension and Staff Payroll Data was also downloaded by the deadline date. This included the incorporation of fair processing notices to staff on the ESR homepage carousel.

The data matches, were received by ABUHB on 29th January 2021. The matches total 6,616 in number, of which, 6,121 relate to trade creditors standing data. ABUHB will be compliant with the expectations of the Office of Auditor General as a participant in the NFI.

5.3 The LCFS has maintained the following proactive investigation exercises, albeit impeded by Covid restrictions:

- Monitoring of GOS trend data pertaining to claims by GOS Contractors.
- Data mining for outliers and abnormal claiming patterns for common ailment scheme claims by Community Pharmacies.
- Rolling programme of monitoring the medication prescribed on Hospital Directorate medical prescription forms (Paragraph 4.41 above refers in greater detail).

5.4 The Counter Fraud team investigates all referrals of alleged fraud, bribery and/or corruption in accordance with Welsh Government Directions. The LCFS provides the DoF and the NHS Counter Fraud Service (Wales) with a concluding report on each investigation.

5.5 Investigations are anonymised in reports to the Audit Committee. Internal Audit and External Audit receive copies of the LCFS report to the Audit Committee and vice versa. Incorporated in **Appendix 2** are details of the LCFS counter fraud investigations conducted between 1st April 2020 and 31st of March 2021.

5.6 CFS Wales carry out high value complex investigations. If an investigation is linked with the area in which the LCFS operates they may be required to assist the CFS Wales by taking witness statements, assisting in the search of a premises or carrying out interview of witnesses and suspects.

5.7 The LCFS has liaised with the Information Governance Manager who is aware of the work of the LCFS. The LCFS has confirmed that ABUHB is compliant with

registration on the ICO Data Protection Register. The LHB has an extensive and up-to-date information asset register.

5.8 The LCFS actively promotes working in partnership through collaboration and interaction with other agencies. A demonstration of this are cases listed as **(11) & (26)** on **Appendix 2** which in this instance pertains to in this instance, pertains to Police and HMPO.

5.9 Case **(11)** was in collaboration with the Police and information sharing occurred between both agencies. The LCFS provided **nineteen (19)** witness statements and documentary evidence to support a joint LCFS/Police prosecution in this case. The LCFS provided a statement of evidence to HR to support the disciplinary process in relation to investigation **(24)** on **Appendix 2**.

5.10 Additionally, on investigations **(4)(5) & (19)** on **Appendix 2** the LCFS provided evidential support to the professional bodies and actually provided witness statements to the NMC & GMC in these instances.

5.11 The LCFS is committed to pursuing every line of enquiry during an investigation and this includes employing every available investigative technique and resource. A further demonstration that the LCFS utilizes the full range of investigative resources, applies to investigations **(25)(26) & (31)** on **Appendix 2**. These cases demanded a financial investigation under the Proceeds of Crime Act 2002, which was undertaken by an Accredited Financial Investigator attached to Counter Fraud Service (Wales).

5.12 On four occasions historically, ABUHB has provided expenditure for handwriting forensic analysis, to progress LCFS investigations and this is yet further evidence that there is strong political and executive support for work to counter fraud, bribery and corruption. It is apparent that the ABUHB organisation is committed to making financial investments in work to tackle fraud, bribery and corruption which is proportionate to identified risks.

5.13 During 2020/21 the ABUHB LCFS disseminated **twenty (20)** Data Protection requests to external bodies i.e. Police, DWP & UKBA etc, whereby information was sought by the LCFS to progress investigations.

Similarly, **fifteen (15)** Data Protection requests were received by the LCFS from the Police and other agencies, whereby information was sought by law enforcement. This resulted in the release of information by the LCFS and from probity and information governance best practice, the Head of Information Governance was party to all the disclosure.

5.14 Liaison was effected with HMR&C on investigations **(17)(24)(25)(26) & (43)** on **Appendix 2** and gateway authorities were utilised to obtain taxation records as part of these LCFS investigations. In total, **six (6)** requests of this nature were generated.

5.15 Automated number plate recognition evidence (ANPR) was obtained from Heddlu Gwent Police on **five (5)** occasions in relation to investigations **(17)(26) & (31)** on **Appendix 2,** plus two additional occasions.

In addition to this, the LCFS collaborated with Gwent Police to facilitate PNC checks as a consequence of NHSCFA inability to do so following initial Covid lockdown.

5.16 During 2020/21, the LCFS conducted **two (2)** interviews under caution with **two (2)** alleged offenders. The ability of the LCFS to conduct such interviews has been impeded due to Covid restrictions.

5.17 In the event that the LHB has a case of proven fraud, the next step will be to seek to apply an appropriate sanction. There are three different types of sanctions which can be followed parallel to each other. The sanctions are as follows:

- LHB Disciplinary Procedure: Applicable to NHS staff only. Contractors can be referred to the relevant professional body.
- Civil law Procedures: Applicable where the LHB needs to recover monies lost to fraud that cannot be sought through voluntary payments or the Criminal Courts.
- Criminal law Procedures: to apply an appropriate criminal penalty.

5.18 **Seven (7)** investigations on **Appendix 2** have resulted in prosecution files of evidence being submitted to the Crown Prosecution Service (Paragraph 1.9 above refers).

5.19 **Two (2)** of those cases **(11)** & **(14)** on **Appendix 2** have resulted in criminal convictions.

5.20 **Six (6)** cases **(9)(15)(16)(24)(27)(34)** on **Appendix 2** have resulted in disciplinary action. These generally pertain to dismissal from employment for gross misconduct but include formal written warnings or where staff members have resigned prior to the conclusion of the disciplinary process.

5.21 Investigations **(39) & (40)** on **Appendix 2** are ongoing disciplinary matters which have impending sanctions.

5.22 **Three (3)** cases **(4)(5)** & **(19)** on **Appendix 2** have impending professional sanctions from the professional bodies GMC & NMC.

5.23 The LCFS has sought to maximise the deterrent value of criminal sanctions by publicising them and exploiting media coverage of cases. Four cases which feature as **(4)(8)(11)(14)** on **Appendix 2** received extensive regional media reporting following convictions at Court. This media coverage amplified the deterrent message to any would-be NHS fraudsters.

5.24 It is important that sanctions are applied in a consistent manner according to the seriousness of the fraud, which is believed to be present. All sanctions are carried out in accordance with the NHS policy publication entitled 'Applying Appropriate Sanctions Consistently'. Full compliance is also made to Legal Directions and the NHS counter fraud manual.

5.25 The protocol between the Counter Fraud Specialist and Workforce & OD (referred to previously at paragraph 2.2 above) outlines the procedure that should be followed if a staff member is being investigated for fraud. The protocol ensures that both parties work together to ensure that any disciplinary action does not affect any criminal investigation. The implementation of the protocol by the LHB ensures consistency in working practices and will be supportive of the Counter Fraud provision and the LCFS. Consideration in this domain is also given to the NHSCFA policies on Parallel Criminal and Disciplinary Investigations.

5.26 The Covid lockdown essentially brought the Criminal Justice court process to a standstill and impending prosecutions were severely delayed with the closure

of law courts. Additionally, under the Crown Prosecutors Code, it is evident that the emphasis in relation to public interest considerations were affected in the decision making process applied by the CPS.

Under the Crown Prosecutors Code, each case under consideration must pass two individual tests before it can proceed to court, firstly the evidential test and secondly the public interest test. If a case fails the evidential test then no consideration should be given to public interest factors irrespective of how serious a case may be.

Investigation listed as case number **(19)** on **Appendix (1)** was subject of a charging decision by the CPS and charging permission was denied because the case failed to meet the public interest test, despite passing the evidential threshold. Pre-Covid, such a case would have undoubtedly resulted in a criminal court case.

5.27 The criminal investigations conducted by the LCFS during Covid lockdown continued virtually unhindered throughout their evidential gathering phases. Towards the conclusion of any such investigation, following the evidence gathering stage, if areas of concern are found to be prevalent, there is the requirement to conduct an audio recorded interview under caution, with the defendant, in the presence of their Solicitor. Due to Covid restrictions, such interviews ceased and an impasse occurred whereby interviews under caution began to amass. As time progressed, having due regard to personal safety of all concerned including risk assessment, the LCFS sought executive endorsement to resume interviews under caution. The first interview of this nature following Covid lockdown was conducted on 22nd September 2020, with a further interview taking place on 11th December 2020. Further planned interviews under caution have been suspended since the second Covid lockdown in Wales.

5.28 Fraud whistleblowing referrals have continued to be received by the LCFS but the dynamic for raising fraud concerns has changed during the Covid crisis. Pre-Covid, the most common method of this type of referral was by means of the fraud referral form downloaded from the Counter Fraud web-pages on the ABUHB intranet site. Since Covid lockdown, fraud referrals have all but exclusively been received via the NHS 0800 national fraud & corruption reporting line which is linked to crime-stoppers.

5.29 In all cases, the LCFS, in agreement with the DoF, seeks to recover monies lost to the LHB as a result of fraud and corruption. Recoveries totalling **£47,443.54** were made against investigations listed as numbers **(11) (14) (20) (25) (27) (34) & (46)** on **Appendix 2** of this report. The LCFS also seeks to maximise possible sanctions against the perpetrator. Effective recovery can benefit from other work performed by the LCFS to professionally investigate, to seek to apply sanctions and develop an anti-fraud culture.

5.30 The LCFS keeps a record of the outcome of all investigations including details of recoveries being sought. The LHB has procedures in place for recovering money lost to fraud and the recoveries policy is enforced and adhered to rigidly.

6 Counter Fraud Arrangements

6.1 CFS (Wales) the regional arm of NHSCFA, hold All-Wales bi-annual summits at which all LCFS's who work within the NHS in Wales are required to attend.

6.2 The meetings give the LCFS an opportunity to share best practice with other Counter Fraud Specialists and to receive training and updates on legislation relating to criminal investigations.

6.3 During 2020/21, such meetings were held on 15th October 2020, 18th November 2020, 2nd February 2021 & 15th March 2021. Additionally, the latter two meeting were also attended by NHSCFA Q.A. Managers. The ABUHB Lead LCFS attended these meetings.

6.4 The Lead LCFS has regularly met/liaised with the DoF during 2020/21 to monitor the progress against the Counter Fraud workplan. The LCFS has regular interaction with the DoF relating to fraud investigations, to highlight potential fraud risks and to circulate fraud notices. These meetings are customarily scheduled on a monthly basis.

On behalf of ABUHB, the DoF is also the authority for prosecution. These meetings are scheduled at paragraph 2.15 of this report.

6.5 The Counter Fraud team consistently takes action to develop new skills for Counter Fraud, and where necessary attends the relevant training courses and workshops. NHSCFA Q.A. Managers provided training inputs at the all Wales forums referred to at paragraph 6.3 above. This training pertained to Quality Assurance.

6.6 Further to the above, the ABUHB LCFS undertook the following training sessions during 2020/21:

- National Counter Fraud Foundation Training
- CFA Clue-3 Training x 2
- Govt Net ICT Conference
- National Public Sector Counter Fraud Summit
- CFA Fraud Investigations Webinar
- Dangos Information/Training session
- CFA Risk Assessment Training/webinar
- CFA Clue Bergerac Update
- MS Teams Training
- Exploring the Challenges of CF within the NHS/webinar

6.7 The Lead LCFS has ongoing liaison throughout the financial year with CFS (Wales) with regards to ongoing measures that the Counter Fraud Team has to adhere to. During 2020/21 the Counter Fraud Team has submitted quarterly statistics to CFS (Wales) which included Counter Fraud work and risks identified.

6.8 The Lead LCFS presented the Counter Fraud workplan for 2020/21 which was duly agreed by the DoF. The LCFS identified areas of greatest risk that needed addressing. The workplan is a dynamic document and is regularly updated to ensure that it is reflective of the LHB's needs.

6.9 By the submission deadline date of 30th April 2021, ABUHB Counter Fraud will submit a standards self-assessment review to NHSCFS, Quality Assurance. This review is based on the Standards for NHS Bodies (Wales) and will reflect the ABUHB Counter Fraud provision for 2020/21. The NHSCFA Quality Assurance Team scrutinise the counter fraud provision and assess for embedded counter fraud arrangements and evidence of qualitative outcomes. The resulting report will be presented to Audit Committee for its recommendations to be implemented accordingly.

6.10 Counter Fraud work is a standing item on the Aneurin Bevan University Health Board's Audit Committee meeting agenda. During 2020/21, the LHB Lead LCFS was required to attend and report at **three (3)** such Audit Committee meetings for the LHB i.e. 2nd April 2020, 22nd October 2020 & 4th February 2021.

6.11 During 2018/19 the LCFS referred one case to Counter Fraud Service (Wales) for investigation relating to a primary care ophthalmic contractor for potential GOS fraud. This investigation is still on-going.

Appendix 1

1. Reporting lines

Chief Executive	Mrs. Judith PAGET Aneurin Bevan University Health Board H.Q. St Cadocs Hospital Lodge Road Caerleon Newport NP18 3XQ Email: Judith.paget@wales.nhs.uk
Director of Finance	Mr. Glyn JONES Aneurin Bevan University Health Board H.Q. St Cadocs Hospital Lodge Road Caerleon Newport NP18 3XQ Email: Glyn.Jones7@wales.nhs.uk
Head of Counter Fraud	Martyn EDWARDS Counter Fraud Aneurin Bevan University Health Board 2nd Floor, Block C, Mamhilad House Mamhilad Park Estate Pontypool NP4 0YP Email: Martyn.edwards3@wales.nhs.uk
Local Counter Fraud Specialist	Gareth LAVINGTON Counter Fraud Aneurin Bevan University Health Board 2nd Floor, Block C, Mamhilad House Mamhilad Park Estate Pontypool NP4 0YP Email: Gareth.lavington@wales.nhs.uk
Local Counter Fraud Specialist	Joanne BODENHAM Counter Fraud Aneurin Bevan University Health Board 2nd Floor, Block C, Mamhilad House Mamhilad Park Estate Pontypool NP4 0YP Email: Joanne.bodenham@wales.nhs.uk

2. Further Information\Mix of cases

Number of cases as at 31st of March 2021, including those brought forward from previous year:

Area (based on Initial reported category)	Number of Cases	Closed	Ongoing
Contractor – Pharmacy (Falsify dispensing charges)	1	0	1
Contractor – Dental (Prescription misuse)	1	0	1
Contractor – GP Staff (Fraudulent prescribing)	3	2	1
Contractor – GP Staff (Theft of monies)	2	1	1
Contractor – GP (Falsify application for performers list	1	0	1
Patient – (Multiple registration at GP Practices)	1	1	0
Patient – (Prescription fraud)	2	2	0
Patient – (Overseas visitor obtain NHS treatment)	1	1	0
Member of Public - (Falsify NHS documents)	1	1	0
Staff – (Falsely obtain paid leave)	2	1	1
Staff – Doctors (Private work in NHS time)	3	1	2
Staff – Doctor (Working whilst on sick-leave)	1	0	1
Staff – (Falsify CV to obtain post)	2	1	1
Staff – (Contract fraud)	1	0	1
Staff – (Computer misuse)	1	1	0
Staff - (Working on sick leave)	10	6	4
Staff – (Dishonest retention of salary overpayments)	2	2	0
Staff - (Falsified expenses/timesheets)	8	3	5
Staff – (Theft/fraud)	2	0	2
Staff – (Failing to complete contracted hours)	3	3	0
Totals	**48**	**26**	**22**

3. NHS Counter Fraud Authority Website

Information about NHS Counter Fraud Authority and the NHS Counter Fraud Strategy can be found at https://cfa.nhs.uk/

Appendix 2

INDEX OF LCFS INVESTIGATIONS AS AT 31st March 2021					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
1.	WARO/18/00048	ABUHB	Community Pharmacist	Falsely claiming pharmacy fees.	Investigation ongoing.
2.	WARO/18/00073	ABUHB	NHS Staff	Failure to complete contracted hospital sessions.	NFA on criminal aspect. No disciplinary issue identified. Case closed on 28/10/2020.
3.	WARO/18/00084	ABUHB	NHS Staff	Failure to complete contracted hospital sessions.	Investigation ongoing.
4.	WARO/18/00106	ABUHB	NHS Staff	Working elsewhere whilst on sick leave and falsification of NMC revalidation paperwork.	At Merthyr Crown Court on 29/11/2019, defendant was convicted of fraud and sentenced to 8-month imprisonment. Defendant resigned from employment with ABUHB prior to disciplinary outcome. NMC action is impending.
5.	WARO/18/00122	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	Recovery of £3,996.43. At Newport Magistrates Court on 26/04/2019, defendant was convicted of fraud. Sentenced to Community Order for 12-months, 100 hours unpaid work. Pay £85.00 costs and £85.00 victim surcharge. Disciplinary and professional action has also been implemented by ABUHB and GMC.
6.	WARO/18/00136	ABUHB	NHS Staff	Timesheet fraud.	Investigation ongoing.
7.	WARO/18/00154	ABUHB	GP Practice Staff	Fraudulent prescribing.	Subject dismissed from employment for gross misconduct on disciplinary hearing on 05/04/2019. NFA on criminal aspect. Case closed 28/10/2020.
8.	WARO/18/00169	ABUHB	Member of public	Falsification of medical history using ABUHB letter	Defendant convicted of fraud. At Newport Crown Court on 16/08/2019, the

INDEX OF LCFS INVESTIGATIONS AS AT 31st March 2021					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
				headed paper to misappropriate charity funds.	defendant was sentenced to 12-months imprisonment suspended for 15-months and was ordered to undertake a 15-day rehabilitation requirement, perform 120-hours unpaid work and pay court costs of £340.00. Case closed 28/10/2020.
9.	WARO/19/00034	ABUHB	NHS Staff	Irregularities with job application form as well as professional issues.	Employee dismissed from employment for gross misconduct on disciplinary hearing. Criminal investigation ongoing.
10.	WARO/19/00046	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	NFA on criminal aspect. No disciplinary issue identified. Case closed on 29/09/2020
11.	WARO/19/00057	ABUHB	Member of public	Prescription fraud.	Defendant charged with 11-counts of fraud. Appeared at Cardiff Crown Court on 10/02/2021. Sentenced to imprisonment for 30-weeks, suspended for 12-months. 20-day rehabilitation activity requirement. Costs £720.00. Compensation £1,813.58, victim surcharge £156.00. Case closed 03/03/2021.
12.	WARO/19/00061	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	NFA on criminal aspect. No disciplinary issue identified. Case closed on 29/09/2020
13.	WARO/19/00068	ABUHB	NHS Staff	Falsification of timesheets.	NFA on criminal aspect. No disciplinary issue identified. Case closed on 30/10/2020.
14.	WARO/19/00110	ABUHB	GP Practice Staff	Theft of cash income at G.P. Practice.	Following dismissal from post the Defendant was charged with fraud, appeared at Newport Magistrates Court on 31/07/2020. Received a sentence of 26-weeks

INDEX OF LCFS INVESTIGATIONS AS AT 31st March 2021					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
					imprisonment suspended for 24-months, RAR 20 days, ordered to pay comp of £3,882.70, costs of £85.00 and Victim Supplement of £115.00. Case closed 25/02/2021.
15.	WARO/19/00147	ABUHB	NHS Staff	Falsification of employment application.	Subject fixed term appointment terminated as sanction. NFA on criminal aspect. Case closed on 14/10/2020.
16.	WARO/19/00146	ABUHB	NHS Staff	Computer misuse.	Subject received a verbal warning as a disciplinary sanction. NFA on criminal aspect. Case closed 16/04/2020.
17.	WARO/19/00145	ABUHB	NHS Staff	Falsify WLI claims.	Subject has been interviewed under caution. Case file submitted to the CPS on 24/11/2020 for charging decision.
18.	WARO/19/00140	ABUHB	NHS Staff	Falsely obtain paid absence.	NFA on criminal aspect. No disciplinary issue identified. Case closed on 11/01/2021.
19.	WARO/19/00122	ABUHB	General Practitioner	Falsify information on application for Welsh G.P. performers list.	Subject has been interviewed under caution. CPS declined to charge. Subject has been suspended from practising by GMC pending fitness to practice hearing.
20.	WARO/19/00111	ABUHB	NHS Staff	Falsify bank shift claims.	NFA on criminal aspect. No disciplinary issue identified. Recovery of £124.00 made. Case closed on 28/10/2020.
21.	WARO/19/00107	ABUHB	NHS Staff	Fail to complete contracted hours.	NFA on criminal aspect. No disciplinary issue identified. Case closed on 28/10/2020.

INDEX OF LCFS INVESTIGATIONS AS AT 31st March 2021					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
22.	WARO/20/00005	ABUHB	Member of public	Falsely obtaining NHS services as overseas visitor.	NFA on criminal aspect. Case closed on 28/04/2020.
23.	WARO/20/00012	ABUHB	NHS Staff	Fail to complete contracted hours.	NFA on criminal aspect. No disciplinary issue identified. Case closed on 01/05/2020.
24.	WARO/20/00020	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	NFA on criminal aspect. Dismissed from employment on 21/10/20 following disciplinary action.
25.	WARO/20/00028	ABUHB	NHS Staff	Dishonest retention of salary overpayment.	NFA on criminal aspect. No disciplinary issue identified. Voluntary repayment, full overpayment of £32,087.56 made by subject following intervention by LCFS. Case closed on 21/01/2021.
26.	WARO/20/00046	ABUHB	Agency Nurse	Timesheet fraud.	Investigation ongoing.
27.	WARO/20/00048	ABUHB	NHS Staff	Timesheet fraud.	Subject resigned from post. Voluntary repayment of £220.00. NFA on criminal aspect. No disciplinary issue identified. Case closed on 05/06/2020.
28.	WARO/20/00051	ABUHB	NHS Staff	Contract fraud.	Investigation ongoing.
29.	WARO/20/00053	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	NFA on criminal aspect. No disciplinary issue identified. Case closed on 10/06/2020.
30.	WARO/20/00066	ABUHB	G P Practice Staff	Prescription fraud.	Investigation ongoing.
31.	WAR0/20/00070	ABUHB	G P Practice Staff	Theft of income at G.P. Practice.	Investigation ongoing.
32.	WARO/20/00071	ABUHB	Member of public	Prescription fraud.	NFA on criminal aspect. Case closed on 14/09/2020.
33.	WARO/20/00072	ABUHB	NHS Staff	Timesheet fraud.	Investigation ongoing.

INDEX OF LCFS INVESTIGATIONS AS AT 31st March 2021					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
34.	WARO/20/00083	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	NFA on criminal aspect. Staff member resigned prior to disciplinary action. Recovery of £2,399.70 made. Case closed on 21/01/2021.
35.	WARO/20/00099	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	Investigation ongoing.
36.	WARO/20/00101	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	Investigation ongoing.
37.	WARO/20/00108	ABUHB	Dental contractor	Prescription misuse.	Investigation ongoing.
38.	WARO/20/00109	ABUHB	G P Practice Staff	Prescription fraud.	NFA on criminal aspect. No disciplinary issue identified. Case closed on 27/11/2020.
39.	WARO/20/00110	ABUHB	NHS Staff	Theft of NHS equipment.	Investigation ongoing.
40.	WARO/20/00111	ABUHB	NHS Staff	Falsely obtain compassionate leave.	Investigation ongoing.
41.	WARO/20/00121	ABUHB	NHS Staff	Failure to complete contracted hospital sessions.	NFA on criminal aspect. No disciplinary issue identified. Case closed on 21/01/2021.
42.	WARO/21/00001	ABUHB	NHS Staff	Timesheet fraud.	Investigation ongoing.
43.	WARO/21/00002	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	NFA on criminal aspect. No disciplinary issue identified. Case closed on 12/02/2021.
44.	WARO/21/00003	ABUHB	NHS Staff	Theft of medication.	Investigation ongoing.
45.	WARO/21/00004	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	NFA on criminal aspect. No disciplinary issue identified. Case closed on 03/02/2021.
46.	WARO/21/00006	ABUHB	NHS Staff	Dishonest retention of salary overpayment.	NFA on criminal aspect. No disciplinary issue identified. Case closed on 12/01/2021.

INDEX OF LCFS INVESTIGATIONS AS AT 31st March 2021					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
					Full recovery of £6,916.00 made.
47.	WARO/21/00026	ABUHB	Member of public	Multiple registration at G.P. Practices.	NFA on criminal aspect. Case closed on 01/03/2021.
48.	WARO/21/00039	ABUHB	NHS Staff	Timesheet fraud.	Investigation ongoing.

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Audit, Finance & Risk Committee Thursday 8th April 2021 Agenda Item: 4.2

Aneurin Bevan University Health Board

Annual Counter Fraud Workplan - 1st April 2021 to 31st March 2022

Executive Summary

An executive overview has been prepared for the Aneurin Bevan University Health Board (ABUHB) Audit Committee. It highlights the Counter Fraud work which is proposed to be undertaken by the Local Counter Fraud Specialist (LCFS) for 2021/22. This workplan encompasses all the components of Government Functional Standard GovS 013: Counter Fraud, which is due to take effect over the NHS Counter Fraud provisions on 1st April 2021.

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	√
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	√

Executive Sponsor: Glyn Jones - DoF

Report Author: Martyn Edwards – Head of Counter Fraud

Report Received consideration and supported by : DoF

Executive Team		**Committee of the Board [Committee Name]**	**Audit Committee**

Date of the Report: 19th March 2021

Supplementary Papers Attached: No

Purpose of the Report

The Workplan requires to be approved by the DoF and ratified by Audit Committee.

Background and Context

This document has been prepared by the Aneurin Bevan University Health Board Counter Fraud Team in order to facilitate mapping the provisions of the Government Functional Standard GovS 013: Counter Fraud and the recommendations of the NHS Counter Fraud Authority.

Assessment and Conclusion

This report will contribute towards the Quality Assurance Self-Review as evidence that the LHB has complied with Government Functional Standard GovS 013: Counter Fraud. The report content and style complies with the model prescribed by the NHS Counter Fraud Authority (NHSCFA) for Quality Assurance Assessment.

Recommendation

This report is intended for Audit Committee information and views.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	N/A
Financial Assessment, including Value for Money	N/A
Quality, Safety and Patient Experience Assessment	N/A
Equality and Diversity Impact Assessment (including child impact assessment)	N/A
Health and Care Standards	N/A
Link to Integrated Medium Term Plan/Corporate Objectives	N/A
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** N/A
	Integration – N/A
	Involvement – N/A
	Collaboration – N/A
	Prevention – N/A
Glossary of New Terms	N/A
Public Interest	N/A

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

ABUHB Finance, Audit & Risk Committee
Date: 8th April 2021
Agenda item: 4.2

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

COUNTER FRAUD, BRIBERY & CORRUPTION WORK-PLAN 1st APRIL 2021 to 31st MARCH 2022

Strictly Confidential

This document is prepared by the Aneurin Bevan University Health Board Counter Fraud Team in order to comply with Government Functional Standards and the recommendations of the NHS Counter Fraud Authority for NHS Bodies (Wales) and has been approved by the Director of Finance.

WORKPLAN 2021-2022

1 Background

1 On 29th January 2021, the NHS rolled out new counter fraud requirements for NHS-funded services in relation to the Government Functional Standard GovS 013: Counter Fraud. The NHSCFA worked closely with a wide range of stakeholders to ensure that the NHS Counter Fraud Requirements had greater consistency and remained fit for purpose for organisations, including providers and commissioners. The standards apply to all NHS funded services (those receiving partial or full NHS funding).

The purpose of the Government Functional Standard is to set expectations for the management of fraud, bribery and corruption risk across government and wider public services, and to reinforce the government's commitment to fighting fraud against the public sector. The final engagement which sealed the implementation of the Government Functional Standard GovS 013: Counter Fraud occurred at the All Wales DoF's meeting on 19th February 2021.

The NHSCFA is responsible for leading and influencing the improvement of counter fraud standards across the NHS and will be responsible for ensuring the effective implementation of the NHS Counter Fraud Requirements. The requirements have superseded our own fraud, bribery and corruption standards for providers, commissioners and NHS bodies in England and Wales.

The NHSCFA is required to provide assurance to the Cabinet Office of NHS compliance with the Functional Standard. This will be accomplished by the receipt and validation by the NHSCFA of the Counter Fraud Functional Standard Return submitted by organisations providing any NHS funded services. The Quality Assurance Programme will enable the analysis of trends and patterns in performance in relation to each requirement.

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1.1 This Work-Plan provides a basis to formulate Local Counter Fraud arrangements for Aneurin Bevan University Health Board. The tasks outlined should be considered and reviewed on an annual basis. This guidance recommends the resources necessary to undertake work effectively across the areas of action outlined in NHS Counter Fraud Policy and Procedures. These recommendations are based on the Government Functional Standard 013: which replaces the previous NHS specific Standards for Fraud, Bribery and Corruption (Standards). Together with stakeholders the NHSCFA have developed new NHS Requirements to meet the Functional Standard.

1.2 The Health Board follows the Welsh Government Directions on Countering Fraud, Bribery and Corruption within the NHS in Wales and employs a dedicated, professionally accredited team of NHS Local Counter Fraud Specialists (LCFS), to undertake the role of countering fraud within the Health Board.

1.3 To ensure that the Health Board's resources remain resilient to the risk of fraud, bribery and corruption, an Annual Work-Plan is compiled by the LCFS and submitted to the Audit Committee for approval at the commencement of each financial year.

1.4 The LCFS' are aware of the importance of liaison with External Auditors when planning Local Counter Fraud work in order to prevent duplication of effort. There are some elements of the Counter-Fraud Work-Plan which External Auditors may review on a risk basis as part of their own reviews of Governance Arrangements, e.g. Whistle-Blowing arrangements, Declaration of Interests; Gifts and Hospitality. External Auditors will certainly be seeking to gain assurance that Counter Fraud arrangements are robust.

1.5 **NHS Counter Fraud Authority Fraud, Bribery and Corruption Strategy**

NHS Counter Fraud Authority has published new counter fraud requirements to ensure compliance with Government Functional Standard GovS 013: Counter Fraud. Together with stakeholders the NHSCFA have developed new NHS Requirements to meet the Functional Standard. The Work-Plan below provides detail of where Standards have been aligned to the new NHS Requirements, under 4 key principle headings:

- **Strategic Governance –** This sets out the standards in relation to the organisation's strategic governance arrangements. The aim is to ensure that anti-crime measures are embedded at all levels across the organisation.

- **Inform and Involve –** This sets out the requirements into raising awareness of crime risks against the NHS and working with NHS staff, stakeholders and the public to highlight the risks and consequences of crime against the NHS.

- **Prevent and Deter –** This sets out the requirements in relation to discouraging individuals who may be tempted to commit crimes against the NHS and ensuring that opportunities for crime to occur are minimised.

- **Hold to Account –** This sets out the requirements in relation to detecting and investigating crime, prosecuting those who have committed crimes and seeking redress.

1.6 NHS Counter Fraud Authority (NHSCFA) has also published detailed information on how the new Government Functional Standard 013 will be applied across the NHS and wider Health Group. The Health Board's 2021-22 Work-Plan for Local Counter Fraud work will therefore closely mirror this Standard and Provider's Guidance, which in turn supports the objectives set by the Welsh Government.

1.7 The total number of suggested **Pro-Active days** to be allocated in 2021-22 is **312** (out of a total of resource of 535 workdays) this *excludes* the resource required for undertaking 'Reactive' Local Counter Fraud work (Hold to Account). This reactive resource is required to conduct detailed investigations into allegations received by the Health Board in relation to NHS Fraud, Bribery and Corruption. The total number of **Reactive days** to be allocated in the 2020-21 Work-Plan is **223** (inc proactive investigations).

1.8 Pro-Active work (i.e. Key Principles: Strategic Governance, Inform & Involve and Prevent & Deter) should not be absorbed by reactive activity or *vice versa* and to this end NHSCFA strongly encourages Pro-Active work to be 'ring-fenced'. Effective Pro-Active work needs to be undertaken otherwise the Health Board may be at risk from Fraud, Bribery and/or Corruption.

1.9 The guidance previously provided by NHSCFA in relation to the recommended allocation of work days based on the size of the NHS organisation is as follows:

Number of staff	Number of Pro-Active Counter Fraud days
Less than 4,999	295
5,000 to 9,999	305
10,000 to 13,999	315
More than 14,000	325

1.10 Organisations that fall below this guidance should be able to provide evidence as to why decisions on work planning have been taken and these should be provided to NHSCFA upon request.

2 Taking a risk-based approach to planning local counter fraud work

2.1 During 2013-14 NHSCFA issued a 'Standards Self Review Tool' template to support NHS organisations in assessing if they are meeting the recommended 'Standards for Providers for Fraud Bribery and Corruption'.

2.2 The Work-Plan is a framework on which to build robust Counter Fraud arrangements and is therefore analogous with the 'Standards Self Review Tool' that Health Boards are requested to submit to NHSCFA at the end of the financial year.

2.3 Those who are locally based are best placed to identify and understand the Counter Fraud requirements for their organisation. The successful implementation of NHS Policy for Countering Fraud, Bribery and Corruption relies greatly on the success of the Local Counter Fraud Specialist (LCFS) role.

2.4 Meeting with key personnel within the Health Board is crucial to information gathering and, along with staff survey results, can assist in the formulation of planning and provide information on the most effective methods of communication. Responses may also indicate areas of perceived risk and this may also be supported by previous experiences which could highlight a need for Pro-Active preventative or detection work.

2.5 The LCFS should have effective liaison with the Local Risk Manager and Risk Group. It is recommended that frauds that have occurred within the organisation and beyond be brought before this group to ascertain the risk to the Health Board from the same type of fraud. Once identified, the fraud can be proactively addressed.

2.6 Risks identified by the LCFS need to be placed onto the appropriate Risk Register to provide another level of assurance that the risk will be managed appropriately.

2.7 Whilst every effort should be made to identify local risks, it is also important that consideration is given to information provided from outside the organisation (for example, from NHSCFA fraud alerts) and this too must be incorporated into risk-based planning in the same way that local information is.

2.8 Keeping accurate records of Counter Fraud work is crucial for successful work-planning as is utilising previous LCFS outcomes, Risk Register entries and Internal Audit Reports. The end of year assessment also encourages accurate record keeping and accountability and the end of year declaration should also be used to identify strengths and weaknesses.

3 Focusing on outcomes and not merely activity

3.1 The Counter Fraud work that is completed at the organisation should have outcomes that are demonstrable, they might relate to successful investigations or progress being made in the proactive areas. For example, the staff survey supports progress being made in developing an Anti-Fraud Culture or that Fraud Proofing Policies has seen a cessation of referrals from that particular area. Clearly the NHS must get value for the money it spends on Counter Fraud work and in planning for the year ahead consideration needs to be given to obtaining evidence to demonstrate this is happening.

Risk Assessment of Counter Fraud Arrangements

Approach

1.1 The Standards for NHS bodies Wales necessitated the need to review the use of the previous Risk Assessment Tool (RAT) issued by NHSCFA and adopt the revised Qualitative Assurance Process to assess the Local Counter Fraud provision within the Health Board. This revised process is based on a traffic light rating system (**Green**, **Amber** and **Red**).

1.2 Adopting a risk based approach to counter fraud work is important on many levels and helps to ensure that bespoke arrangements are put in place for the health care organisation being served. A risk based approach demonstrates the rationale for planning to undertake counter fraud work together with importance of conducting that work. This is a significant factor when demonstrating value for money, efficiency and service improvement; allowing ABUHB to achieve its strategic themes and priorities.

1.3 The revised Qualitative Assurance Process has allowed a thorough self-assessment of the counter fraud arrangements which are in place across Gwent to be undertaken. This enables the strengths and weaknesses throughout ABUHB to be identified. By managing identified weaknesses, the organisation will be able to demonstrate that it has implemented robust counter fraud measures across the range of tasks.

1.4 This twelve month Counter Fraud Work-Plan has been prepared by the ABUHB LCFS Team in consultation with the Director of Finance and is designed to manage the perceived counter fraud risks within ABUHB.

1.5 The overall risk assessment of organisational Counter Fraud Arrangements on 31st March 2021 was rated **Green** (Score- 100%) in all areas.

1.6 Summary of Risk Level Assessment contained in the Standards Self Review Tool is as follows:

Suggested Response to Summary Outcomes

It is anticipated that the outcomes in each of the area of action support the following response:

Green	Meets the standard
Amber	Partially meets the standard
Red	Does not meet the standard

Summary of risk assessment outcome

1.7 The summary assessment by the ABUHB Counter Fraud Team of each Key Section at 31st March 2021 is shown in the table below:-

Key Section	Strategic Governance	Inform & Involve	Prevent & Deter	Hold to Account	Overall 'Green' risk assessment rating of Counter Fraud Arrangements (100%)
Overall risk assessment rating by generic area	**Green**	**Green**	**Green**	**Green**	**Total score across all Key Sections**
Number of red ratings by key sections	**0**	**0**	**0**	**0**	**0**
Number of amber ratings by key sections	**0**	**0**	**0**	**0**	**0**
Number of green ratings by key sections	**20**	**6**	**12**	**13**	**51**
TOTALS	**20**	**6**	**12**	**13**	**51 (100%)**

1.8 The policies considered to be immediately critical to the Counter Fraud Agenda, are as follows:-

- Declaration of Interest Protocol/Form
- Standing Financial Instructions
- Counter Fraud, Bribery & Corruption Policy
- Disciplinary Policy
- Staff Code of Conduct Policy
- Whistle Blowing Policy
- Counter Fraud Communication Strategy
- Counter Fraud and HR Protocol
- Counter Fraud Standard Operating Procedure
- Counter Fraud Protocol with Internal Audit

Key Principle 1: STRATEGIC GOVERNANCE					
	Standard & NHS Requirement	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
1.1	**(Component 1 NHS Req.1A)** **A member of the executive board or equivalent body is accountable for provision of strategic management of all counter fraud, bribery and corruption work within the organisation. The accountable board member is responsible for the provision of assurance to the executive board in relation to the quality and effectiveness of all counter fraud, bribery and corruption work undertaken.** **The accountable board member is responsible for ensuring that nominations for the accountable board member, audit committee chair and counter fraud champion are accurate and any changes are notified to the NHSCFS Wales at the earliest opportunity, in accordance with the nominations process.**	Lead LCFS (Counter Fraud Champion) to hold regular scheduled meetings with DoF, objectives to be reviewed and work to date evaluated. During these meetings target audiences will be identified for presentations in line with promoting counter fraud work within the organisation. The DoF to act as the link between the Audit Committee and Risk Management Group to allow key risks to be identified, managed and mitigated. The LCFS to produce the ABUHB Counter Fraud Annual Report & Workplan which is to be agreed with the DoF and ratified by the Audit Committee.	DOF in post clear reporting lines established		2 18
1.2	**(Component 1 NHS Req.1B)** **The organisation's non-executive directors, counter fraud champion or lay members and board/governing level senior management are accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and**	The LCFS will hold regular one to one meetings with the Audit Committee Chairperson. In addition to this LCFS to attend pre-audit committee meetings with non-executive Audit Committee and Board Members Preparation and attendance at audit committee meetings. (Including progress reports). Counter Fraud is a standing agenda item at Audit Committee. The LCFS to provide written and oral reports to this forum.			8 6

Key Principle 1: STRATEGIC GOVERNANCE					
	Standard & NHS Requirement	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
1.3	**corruption are present within the organisation.** **The CF champion understands the threat posed and promotes awareness accordingly.** **Board level evaluation of the effectiveness of counter fraud, bribery and corruption work undertaken should be documented. Where recommendations have been made by NHSCFA following an assessment, it is the responsibility of the accountable board member to provide assurance to the board surrounding the progress of their implementation.** **The organisation reports annually on how it has met the requirements set by NHSCFA in relation to counter fraud, bribery and corruption work, detailing corrective action where requirements have not been met.**	The LCFS to facilitate the organisation's ongoing commitment to continue to fund promotional 'giveaway' material promoting and identifying the counter fraud department to both internal and external customers and stakeholders. The LCFS to undertake staff surveys to evaluate the level of staff awareness of fraud, bribery and corruption across the health board, to include primary care contractors as well as staff employed directly by the health board. As a result of evaluation implement corrective/preventative measures to ensure counter fraud, bribery and corruption work continues to identify and address areas of organisational risk.			2 12
	(Component 9 NHS Req.9) **The organisation employs one or more accredited nominated LCFSs to undertake the full range of counter fraud, bribery and corruption work, including proactive work to prevent and deter fraud, bribery and**	ABUHB Counter Fraud Team consists of 3 team members (equates to 2.8 WTE), all are fully accredited LCFS personnel. The LCFS will undertake the full range of duties associated with the role on behalf of the organisation. All investigations will comply with all relevant legislation.			10

Key Principle 1: STRATEGIC GOVERNANCE					
	Standard & NHS Requirement	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
1.4	**corruption and reactive work to hold those who commit fraud, bribery and corruption to account.**	All staff will continue to develop professionally, attending appropriate training sessions provided by NHSCFA to enhance their knowledge and skills as well as attending regional forums hosted by NHSCFA and NHS CFS Wales. LCFS will undertake continuing professional development opportunities associated with role. All training and development to be recorded on ESR and referenced during annual staff appraisals.			2
1.5	**(Component 3 NHS Req.3)** **The organisation undertakes a regular and comprehensive fraud risk assessment to identify fraud, bribery and corruption risks, and has a counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. Risks are recorded and managed in line with the organisation's Risk Management Strategy and Processes Policy and are included on the appropriate risk registers. Measures to mitigate identified risks are included in an organisational work plan, progress is monitored at a senior level within the organisation and results are fed back to the Audit Committee.**	The organisation undertakes an honest appraisal of risk across all domains on a rolling programme, focussing on existing arrangements, using appropriate risk assessment techniques/procedures to identify fraud, bribery and corruption risks, with findings reported to the Audit Committee to be recorded on the Audit Committee Risk Register and the overall Corporate Risk Register accordingly. The Audit Committee and DoF to monitor progress to mitigate risks and ensure resources remain suitable for this purpose. LCFS to manage existing arrangements with NWSSP and local Accounts Departments in a bid to prevent payroll and mandate fraud.			5 2
	(Component 1 NHS Req.1B)	LCFS to provide interim reports to Audit Committee at each meeting attended. These reports to include			3

Key Principle 1: STRATEGIC GOVERNANCE					
	Standard & NHS Requirement	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
1.6	**The organisation reports annually on how it has met the standards set by NHSCFA and NHS CFS Wales in relation to counter fraud, bribery and corruption work, and details corrective action where standards have not been met.**	the outcomes of actions against minutes from previous meetings. Preparation for and attendance at audit committee meetings. (including progress reports) LCFS to compile the annual report at the end of the financial year for presentation at the Audit Committee alongside the counter fraud workplan for the coming year. These are to be agreed with the Director of Finance. LCFS to complete the NHSCFA Standards Self Review Tool and present to audit committee.			4 2
	(Referenced in NHS Regs. 3&5) The organisation ensures that those carrying out counter fraud, bribery and corruption work have all the necessary tools and resources to enable them to carry out their role efficiently, effectively and promptly. This includes (but is not limited to) access to appropriate IT systems as well as access to secure storage.	The LCFS maintains the appropriate standards of confidentiality and security as well as having access to the tools and resources necessary to professionally carry out their role and comply with legal requirements. LCFS to continue to have access to secure office accommodation accessible only by them. Secure storage facilities both in the office and on site to be utilised effectively for the necessary retention and storage of evidential data in line with legal requirements. Secure access to relevant IT systems is maintained including NHS Wales email addresses. Continue to maintain and supply data and statistical information to NHS CFS Wales on a quarterly basis using the designated templates supplied. Also provide ad hoc data as and when requested.			6 6 3

Key Principle 1: STRATEGIC GOVERNANCE					
	Standard & NHS Requirement	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
1.7		Implement fraud, bribery and corruption prevention guidance as and when provided by NHS CFS Wales.			
	(Referenced in NHS Regs. 3,5&7) The organisation ensures that there are effective lines of communication between those responsible for counter fraud, bribery and corruption work and other key staff groups and mangers within the organisation, including (but not limited to) audit, risk, finance, communications and human resources. There is evidence of positive outcomes as a result of this liaison.	Liaison with person responsible for HB security arrangements keeping each other informed of local concerns and issues. Maintain unrestricted access to key staff groups e.g. Audit Committee, chairperson and non-executive members. Continue to interact with key managers and stakeholder groups such as NWSSP Payroll Services, Corporate Finance, Information Governance, Internal Audit and HR exchanging relevant information and providing necessary support and guidance. LCFS to maintain and update existing policies and protocols with key stakeholder groups such as payroll services, PPV, HR, Corporate Finance, Internal Audit and Contractor Services. Where fraud, bribery or corruption has been identified, the LCFS will consider the full range of available sanctions – criminal, civil, disciplinary and/or regulatory in line with “Parallel Criminal and Disciplinary Investigations Policy” guidelines.			2 5 4 2 2

Key Principle 1: STRATEGIC GOVERNANCE					
	Standard & NHS Requirement	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
		When requested LCFS to assist with joint operations involving internal and external departments and organisations (HR, Internal Audit, police forces, DWP, UKBA, HMRC).			3

Key Principle 2: INFORM & INVOLVE					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
2.1	**(Component 11 NHS Req.11)** **The organisation has an ongoing programme of work to raise awareness of fraud, bribery and corruption. This should cover NHSCFA's Fraud and Corruption Reporting Line and online fraud reporting tool, and the role of the accredited counter fraud specialist.** **Content may be delivered through presentations, newsletters, leaflets, posters, intranet pages, induction materials for new staff, emails and other media, making use of NHSCFA's fraud awareness toolkit as appropriate. The effectiveness of the awareness programme is measured.**	Review local fraud material generated to promote the counter fraud work being undertaken by the LCFS within HB. Ensure it remains fit for purpose where necessary remove/update information accordingly. Ensure that literature developed by ABUHB contains details of the NHSCFA's Fraud and Corruption Reporting Line and online fraud reporting tool. Where appropriate utilise electronic and written information/ newspaper articles from other HBs to demonstrate the commitment to countering fraud across the Welsh Region. Include details of prosecutions etc. in both staff and contractor newsletters. The LCFS to attend all HB corporate induction training events (where practicable) to provide an input to new staff on the role of the Counter Fraud Department. Material to be regularly reviewed and updated to reflect any changes in legislation, policy or working practices. Evaluate feedback from all presentations, collate results, and where appropriate amend presentations as a result of feedback. Write up a report on the outcomes for the Director of Finance.			5 5 8

Key principle 2: INFORM & INVOLVE					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
		A programme of counter fraud awareness training to be delivered to staff at all levels within the HB (board-level, managerial staff, clinical staff and junior staff). An LCFS should aim to complete at least 15 presentations to staff groups. The aim of this is to ensure the HB is proactive in raising fraud awareness and able to build a genuine anti-fraud, bribery and corruption culture. These should include presentations: • to the Audit and Governance committee • at Staff Forums • to the Professional Executive Committee • to Practice Managers • at Staff Team Briefings • at Management Forums • at General Practitioner Forums • at Pharmacy Forums • to Authorised Signatories • to NHS Contractors (e.g. Dentists, Pharmacists etc) and their staff			15
		Review and update the induction material distributed during the HB's induction process, including slides, handouts, leaflets and CFS forms, ensuring it remains current and in line with any changes to legislation/policy/working practices.			3

Key principle 2: INFORM & INVOLVE					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
		Develop and maintain counter fraud information on the HB intranet also use extranet and public website materials where appropriate. Having a counter fraud site provides staff easy access to counter fraud, bribery and corruption information. Items to include on the site are: • overview of the counter fraud initiative locally and nationally • role of LCFS • Fraud, Bribery and Corruption Policy • proven NHS fraud cases • presentation slides • link to NHSCFA's website • link to appropriate HR policies (including Whistleblowing policy) • contact details of LCFS • feedback form • referral form			8
		The LCFS should be able to ascertain the number of staff visiting the counter fraud intranet site.			1
		LCFS to E-mail an introduction or reminder to senior staff with their contact details, outlining the role they fulfil in the HB. Field the resulting responses and encourage informal communication to build up rapport. Use this opportunity to organise bespoke fraud awareness presentations to specific staff groups.			1

Key principle 2: INFORM & INVOLVE					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
		The LCFS to meet with the practice managers to highlight the role of the LCFS and the obligations of the practice to report suspicions of fraud, bribery and corruption according to HB Policy. Ensure contact details of LCFS are available in all hospitals/offices.			3
		The LCFS to promote fraud awareness by offering to deliver presentations to staff groups on an ongoing basis.			2
		LCFS to meet with key personnel around the HB to discuss fraud matters. To include: • Head of Pharmacy & Prescribing • Contractor Payments Manager • Director of HR • Director of Service Development • Medical Director • Director of Nursing • Agency/Bank Co-ordinator • NWSSP Payroll Manager • Complaints Manager			5
		LCFS to arrange for a pay-slip message promoting counter fraud to be published on a quarterly basis via interaction with NWSSP payroll services.			2

Key principle 2: INFORM & INVOLVE					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
		Undertake Local Fraud Awareness events and other initiatives across the HB. Provide a rolling program of displaying counter fraud material on a site by site basis. Promote contact details and visits by counter fraud enabling staff to discuss any concerns or issues relating to counter fraud.			61
2.2	**(Component 4 NHS Req.4)The organisation has a counter fraud, bribery and corruption policy that follows NHSCFA's strategic guidance, publicises the NHSCFA's Fraud and Corruption Reporting Line and online reporting tool, and has been approved by the executive body or senior management team. The policy is reviewed, evaluated and updated as required, and levels of staff awareness are measured**	Establish/review existing counter fraud bribery and corruption policy, update and amend as appropriate. **Refer to Counter Fraud, Bribery and Corruption Policy for further guidance.** LCFS to ensure effective links between the **Counter Fraud, Bribery and Corruption Policy** including 'online fraud reporting tool' and counter fraud work. Policy/reporting tool to be published on HB intranet site. Utilise staff surveys to evaluate if staff are aware of the policy and how and where to locate it. Also establish that they are aware of the correct procedures associated with reporting fraud, bribery and corruption.			1 1 1
2.3	**(MOG advises on info. requirements) The organisation liaises proactively with other organisations and agencies (including local police, local authorities, regulatory and professional bodies) to assist in countering fraud, bribery and corruption.**	Work closely with the Regional and the Pharmaceutical Fraud Teams in respect of Patient GP registration fraud, and communicate ***'best practice'*** and situation updates to GP surgeries including guidance to minimise the impact of GP multiple registration fraud.			2

Key principle 2: INFORM & INVOLVE					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
	All liaison complies with relevant legislation, such as the Data Protection Act 1998 – General Data Protection Regulation (GDPR), and with relevant organisational policies. The organisation can demonstrate improved investigative and operational effectiveness as a result of the liaison.	The LCFS will engage with investigators from other organisations and agencies (including police, UKBA, DWP, HMRC, local authorities, regulatory and professional bodies, complying with relevant legislation and organisational policies when countering fraud bribery and corruption. Continue to build upon existing relationships already established with other departments, organisations and agencies (including police, UKBA, DWP, HMRC, local authorities, regulatory and professional bodies.			5
		Maintain and review a joint working protocol with Contractor Payments Department to define liaison roles and interaction. This should include the fact that all post payment verification (PPV) reports are forwarded to the LCFS and action is taken as appropriate.			2
		Intelligence from PPV, dental and optical teams is available to identify areas of weakness and to reflect concerns in planning the proactive reviews and to assist any investigations where requested. Review quarterly GOS trend data identifying anomalies in contractor claiming activity and taking necessary action here appropriate.			4
		Utilise NFI database to assist in countering fraud, bribery and corruption within NHS and other organisations.			13

Key principle 2: INFORM & INVOLVE					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
2.4	**Component 12 NHS Req.12) The organisation has a fully implemented code of conduct that includes reference to fraud, bribery and corruption and the requirements of the Bribery Act 2010. The effectiveness of the implementation of the process and staff awareness of the requirements of the code of conduct is regularly tested.**	The LCFS to actively promote to staff the organisations policy on 'Standards of Business Conduct for Employees'. A link to 'The Bribery Act 2010' to remain as a permanent feature on the HB intranet site's home page.			2

Key principle 3: PREVENT AND DETER					
	Functional Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
3.1	**(The Manual of guidance refers) The organisation reviews new and existing relevant policies and procedures, using audit reports, closure reports and guidance from NHSCFA and NHS CFS Wales, to ensure that appropriate counter fraud, bribery and corruption measures are included. This includes (but is not limited to) policies and procedures in human resources, standing orders, standing financial instructions and other finance and operational policies. The organisation evaluates the success of the measures in reducing fraud, bribery and corruption, where risks have been identified.**	The LCFS will ensure that the whistle blowing, disciplinary, standards of business conduct, declaration of interests, gifts and hospitality policies and other relevant HR policies are adequately robust to counter the risk of fraud, bribery and corruption. The LCFS will review existing and new local policies ensuring that they are fraud proofed and fit for purpose. Maintain records of these reviews for reporting purposes.			2 12

Key principle 3: PREVENT AND DETER					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
3.2	**(Component 10 NHS Req.10)** **The organisation uses relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action to address them.** **Relevant information and intelligence may include (but is not limited to) internal and external audit reports, evidence of primary care work, information on outliers, recommendations in investigation reports and information from payroll. The findings are acted upon promptly.**	Where investigations identify system weaknesses the LCFS to suggest policy development or amendments to processes making them more robust against the risk of fraud, bribery and corruption. LCFS where practicable will evaluate effectiveness of recommendations. The LCFS will monitor Drug Alerts and Pharmacy Reward Scheme Processes. Meet regularly with internal audit to discuss potential system weaknesses identified during audits or investigations, highlight work being undertaken by the LCFS, e.g. national or local proactive work. The LCFS to maintain existing relationship with finance and payroll encouraging data sharing in relation to salary and contractor overpayments. Check year to year income and expenditure variances to ascertain unaccounted for fluctuations that could indicate expenditure or income concerns. Suggested areas would include: ➢ *Overtime payments* ➢ *On call payments* ➢ *Travel expenditure* ➢ *Bank and agency usage* ➢ *IT equipment* ➢ *Use of selected external contractors, suppliers, taxi companies etc*			4 2 1 2 5

Key principle 3: PREVENT AND DETER					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
3.3	**(Amalgamated into NHS Req.10) The organisation issues, implements and complies with all appropriate fraud, bribery and corruption intelligence bulletins, prevention guidance and alerts issued by NHSCFA or NHS CFS Wales. In addition, the organisation issues local counter fraud, bribery and corruption warnings and alerts to all relevant staff following guidance in NHSCFA's Intelligence Alerts, Bulletins and Local Warnings Guidance.**	Ensure that any fraud prevention instructions issued by the NHSCFA are actioned and completed.			4
		Return relevant compliance statements. Pass appropriate risk information to the risk manager for possible consultation. Maintain an audit trail of fraud alerts disseminated to both internal and external staff.			
		Use the Systems Weakness Reporting (SWR) form to inform the NHS CFS Wales at the earliest opportunity of any system weaknesses identified during the course of investigations which potentially have national implications.			3
	The organisation has an established system of follow up reviews to ensure that it remains vigilant and that all appropriate action has been taken.	The LCFS will respond promptly to queries from NHS CFS Wales.			1
		Ensure that any Intelligence Bulletins and Local Warning Guidance, issued by NHSCFA are appropriately disseminated to key personnel to avoid HB from falling victim to similar activities. Maintain records of distribution for audit purposes.			2

Key principle 3: PREVENT AND DETER					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
		Where appropriate utilise the intranet site as a medium to raise vigilance for fraud, bribery and corruption activities that could be used to target the HB.			3
		Provide NHSCFA Central Intelligence Unit with information to support the intelligence function using the facilities provided. Information submitted may be about a person, organisation or methodology and should relate to fraud or corruption within the NHS.			2
3.4	**(Amalgamated into NHS Req.10) The organisation ensures that all new staff are subject to the appropriate level of pre-employment checks, as recommended by NHS Employers, before commencing employment within the organisation. Assurance is sought from any employment agencies used that the staff they provide have been subject to adequate vetting checks, in line with guidance from NHS CFS Wales, NHS Employers and Home Office.**	Full employment checks to be conducted in line with NHS Employer's Guidance. These checks to include photographic ID checks, employer's reference checks, Disclosure & Barring checks, right to work in UK (checks to be made with UKBA if necessary), professional registration checks and academic qualification checks. Any anomalies which arise from pre-employment checks to be referred to LCFS for consideration.			1
		The All Wales Employment Policy stipulates that all employees of the HB must inform their manager at the commencement (time of charge) of any criminal proceedings being brought against them and of any criminal conviction(s) or criminal caution received.			1

Key principle 3: PREVENT AND DETER					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
		The HB to ensure that it receives assurances from employment agencies that appropriate vetting checks have been carried out on agency staff being supplied to work for the HB			1
3.5	**(Amalgamated into NHS Req.10) The organisation has proportionate processes in place for preventing, deterring and detecting invoice fraud, bribery and corruption in procurement.**	The LCFS to review and test existing procurement controls ensuring they remain proportionate and fit for purpose. To include tendering processes, procurement processes. Conflict of interest declarations etc. for all staff and in particular procurement staff. Processes to be reviewed by internal and external audit to ensure adherence to financial control procedures are being adhered to and maintained and that staff have received appropriate training to raise awareness.			2 2
3.6	**(Amalgamated into NHS Req.10) The organisation has proportionate processes in place for preventing, deterring and detecting invoice fraud, bribery and corruption, including reconciliation, segregation of duties, processes for changing supplier bank details and checking of deliveries.**	The LCFS disseminates information to finance staff to prevent potential fraudulent activity from internal and external sources. Staff to be briefed in relation to current trends and criminal activities. Maintain clear segregation of duties to prevent potential diversion of NHS funds by finance staff.			3

Key principle 4: HOLD TO ACCOUNT					
Standard		**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
4.1	**(Component 8 NHS Req.8)** **The organisation ensures that the case management system is used to record all reports of suspected fraud, bribery and corruption, to inform intelligence held nationally by NHSCFA and NHS CFS Wales. The case management system is also used to record all system weaknesses identified during the course of investigations and/or proactive prevention and detection exercises.**	The LCFS to utilise case management system to promptly record all allegations where fraud, bribery and corruption are suspected. Undertake mandatory **proactive** exercises as instructed by NHSCFA/NHS CFS Wales. Undertake local **proactive** exercises at the HB as agreed with the Director of Finance. These exercises to be undertaken when information suggests there are reasonable grounds to justify focussing on a particular area. *Exercises that should be considered for local initiatives include:* • *mobile phone use* • *potential for ghost suppliers* • *pre- and post-appointment checks* • *expense claims* • *payroll/timesheet claims/salary overpayments* • *audit concerns of financial abuse occurring due to poor system controls.* These exercises are guided by local proactive work in gathering useful intelligence. All exercises must only be undertaken where there is good reason to do so and only as directed by the Director of Finance.			(Days inc 195) 4 10

Key principle 4: HOLD TO ACCOUNT					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
		Detailed comprehensive reports to be completed on all **proactive** exercises undertaken by the LCFS. Where recommendations have been made the LCFS should, where appropriate, review findings. Where identified, system weaknesses should be noted on case management system and promptly addressed to prevent further potential incidents occurring. The LCFS to ensure that case progress/closure reports to contain detailed recommendations based on investigation findings.			2
4.2	**(Component 8 NHS Req.8)** **The organisation uses the case management system to support and progress the investigation of fraud, bribery and corruption allegations, in line with NHSCFA's guidance.**	The LCFS to be mindful of NHS CFS Wales's current case acceptance criteria when progressing referrals relating to allegations of fraud, bribery and corruption. The LCFS will ensure that all allegations of fraud, bribery and corruption are recorded on FIRST, maintain detailed records of all referrals that have been received. Regular case progress reports are completed which will reflect an accurate up to date account of all work undertaken in relation to an investigation. To include any interactions with CPS, Police, NHS CFS Wales etc.) LCFS to upload all appropriate evidential MG forms onto FIRST, including witness statements and IUC's.			195

Key principle 4: HOLD TO ACCOUNT					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
		LCFS to conduct investigations as required in line with Appendix 5 of the *NHS Counter Fraud and Corruption Manual*, which outlines relevant procedural investigative legislation. The LCFS must ensure that arrangements are in place so that all work is undertaken in an environment conducive to criminal investigation work. This includes the maintenance and appropriate storage of records.			Days inc (195)
4.3	**(MOG and further evidenced by use of Case Management System)** **The organisation shows a commitment to pursuing, and/or supporting NHSCFA and NHS CFS Wales in pursuing, the full range of available sanctions (criminal, civil, disciplinary and regulatory) against those found to have committed fraud, bribery or corruption in primary and secondary care sectors, as detailed in NHSCFA guidance and following the advice of the Operational Fraud Manager in NHS CFS Wales.**	Assist the NHS CFS Wales with information as required for any regional or national fraud cases. Ensure comprehensive information is provided to enable risk exercises to be carried out effectively and submitted in a timely manner. Undertake effective liaison with other HB members of staff including HR and where necessary other relevant Health organisations for example NMC,GDC and GMC, to ensure that sanctions, such as internal disciplinary action is not applied in isolation where there are indications of potential wider fraudulent activity.			1 4

Key principle 4: HOLD TO ACCOUNT					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
		Where cases have been successfully prosecuted the LCFS will communicate the facts of the case to staff and relevant stake holders by publishing information on the HB intranet site, placing newspaper articles on the counter fraud notice boards, notifying NHS CFS Wales of successful outcomes via the use of the advanced warning process.			2
4.4	**(NHS Requirement 9)** **The organisation completes witness statements that follow best practice and comply with national guidelines.**	The LCFS will complete all witness statements and evidential case files in line with NHSCFA best practice model and NHS National File Standards ensuring compliance with legal requirements.			Days inc (195)
4.5	**(NHS Requirement 9)** **Interviews under caution conducted in line with the National Occupational Standards (CJ201.2) and the Police and Criminal Evidence Act 1984.**	The LCFS will plan and prepare for all interviews under caution, developing an interview plan, assessing the suspect's fitness for interview, and setting up an appropriate location. All interviews will be conducted in accordance with legislation (PACE), policy and other guidelines using appropriate interviewing techniques and communication skills. The LCFS will evaluate the interview (including own performance) in line with NOS (CJ201.2) and PACE 1984.			Days inc (195)

Key principle 4: HOLD TO ACCOUNT					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
4.6	**(MOG and further evidenced by use of Case Management System)** **The organisation seeks to recover, and/or supports NHSCFA and NHS CFS Wales in seeking to recover, NHS funds that have been lost or diverted through fraud, bribery and corruption, following an assessment of the likelihood and financial viability of recovery. The organisation publicises cases that have led to successful recovery of NHS funds.**	Maintain comprehensive records of LCFS time spent on each individual investigation so that this can be included in any compensation claim made by the HB. Identify and maintain a record of the actual proven amount of loss to the HB, in order that appropriate recovery procedures can be initiated and progressed where viable. Ensure the HB has a procedure in place to recover funds that have been lost or diverted as a result of fraud, bribery and corruption in line with the HB Counter Fraud, Bribery and Corruption Policy guidelines and as outlined in Sections 10 and 11 of the NHS Counter Fraud, Bribery and Corruption Manual.			2 2 1

Appendix 1

Number of Days agreed for 2021/22 ***535 Days***

Agreed/signed by

Signature: **Date:**

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit, Finance & Risk Committee Thursday 8th April 2021 Agenda Item: 5.1

Aneurin Bevan University Health Board

Finance Report – February (Month 11) 2020/21

Executive Summary

This report sets out the financial performance of Aneurin Bevan University Health Board, for the current month (February) and annual forecast. The financial performance is measured by comparing the expenditure with the budgets as delegated in the Budget Delegation paper agreed at the March 2020 Board meeting, updated for approved in year delegations.

The Health Board has statutory financial duties and other financial targets which must be met. The table below summarises these and the Health Board's performance against them.

Month 11 - February 2021
Performance against key financial targets 20/21
+Adverse / () Favourable

Target	Unit	Current Month	Year to Date	Trend	Year-end Forecast
Revenue financial target To secure that the HB's expenditure does not exceed the aggregate of it's funding in each financial year. *This confirms the YTD and forecast variance.*	£'000	376	(176)	↓	0
Capital financial target To ensure net Capital Spend does not exceed the Capital Resource Limit. *This confirms the curent month and YTD expenditure levels along with the % this is of total forecast spend.*	£'000 £111.194m	5,197 4.7%	90,816 81.7%	↓	£111.849m spend £0.655m variance - Covid - 19
Public Sector Payment Policy To pay a minimum of **95%** of all non NHS creditors within 30 days of receipt of goods / invoice (by Number)	%	96.3%	96.4%	↑	>95%
Cash balances Cash balance held by the Health Board to be less than the advisory figure set by WG of £6m	£'000	3,290	3,290	↑	Within Target Level

Performance against Statutory Requirements 20/21		17/18	18/19	19/20	3 Year Aggregate
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period	✓	-246	-235	-32	-513
Prepare & Submit a Medium Term Plan that is signed off by Welsh Ministers	✓				

- ***As at Month 11, the year to date reported revenue position is a £176k surplus, with a forecast of break-even.***
- ***The forecast position is based on the latest assessment of a range of financial risks and opportunities in the delivery of operational plans.***

The Finance, Audit & Risk Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	

Receive the Report for Assurance/Compliance			√
Note the Report for Information Only			
Executive Sponsor: Glyn Jones – Director of Finance & Performance			
Report Author: Rob Holcombe – Deputy Finance Director			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Public Partnerships & Wellbeing Committee]**	
Date of the Report: 11th March 2021			
Supplementary Papers Attached: Glossary			

Purpose of the Report

This report sets out the following:

- The financial performance at the end of February 2021 and forecast for 2020/21 – against the statutory revenue and capital resource limits,
- The revenue reserve position at the 28th February 2021,
- The Health Board's cash position and compliance with the public sector payment policy, and
- A financial assessment of the risks and opportunities impacting on the financial forecast for 2020/21.

Assessment & Conclusion

1. Revenue Performance

The Health Board produced a Covid-19 financial plan during April 2020, updated to reflect the operational plan for quarter 2 (2020/21) and further updated for the operational plan for quarters 3 and 4. Financial planning assumptions and forecasts are based on the assumptions within this current operational plan.

The Health Board has agreed a level of expenditure which it is likely to incur and the level of funding from Welsh Government has been adjusted to reflect this in 2020/21. This is subject to revision if Covid-19 related costs for mass vaccination, PPE or contact tracing materially change.

The Health Board is aware that changes to Covid-19 responses at a national level may require a materially different local service response and will continue to engage with Welsh Government colleagues to secure the necessary funding to deliver these future programmes.

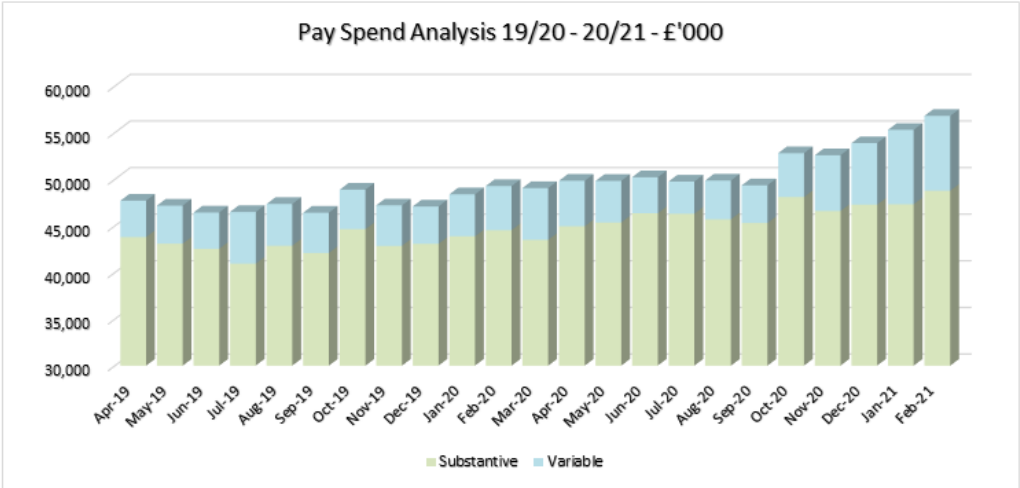
The month 11 year to date position is a **£176k surplus** and the **full year forecast is break-even**. However, there are potential opportunities and risks to the forecast financial position as a result of recruitment challenges and revised Covid-19 response plans, which continue to be reviewed. The key risks and opportunities which may impact on achieving financial balance relate to slippage in costs (e.g. mass vaccination, contact tracing, lower workforce spend), movements in stock levels and annual leave provision. The Health Board is not expecting any change in WRP contributions for this year.

Residual funding is being held to cover other commitments made during this year. It should be noted that the **funding secured is non recurrent only and enables the Health Board to forecast financial balance in this financial year.** A summary of the financial performance is provided in the following table.

Month 11 - February 2021	Full Year Budget £000s	YTD M11 Reported Variance £000s	YTD M10 Reported Variance £000s	Movement M11-M10 £000s
Operational Divisions:-				
Primary Care and Community	263,479	(467)	(1,156)	689
Prescribing	106,506	(44)	(0)	(44)
Community CHC & FNC	65,014	(1,562)	(1,149)	(412)
Mental Health	100,685	886	522	364
Director of Primary Community and Mental Health	5,018	(209)	(157)	(52)
Total Primary Care, Community and Mental Health	**540,703**	**(1,395)**	**(1,940)**	**545**
Scheduled Care	208,366	(1,085)	(607)	(477)
Unscheduled Care	127,238	3,382	2,565	817
Family & Therapies	112,785	(236)	(95)	(140)
Estates and Facilities	76,267	1,245	605	640
Director of Operations	5,442	(406)	(420)	14
Total Director of Operations	**530,098**	**2,901**	**2,047**	**853**
Total Operational Divisions	**1,070,801**	**1,505**	**107**	**1,398**
Corporate Divisions	126,154	(1,021)	(659)	(362)
Specialist Services	157,072	(93)	0	(93)
External Contracts	72,528	0	0	0
Capital Charges	96,773	(0)	(0)	(0)
Total Delegated Position	**1,523,328**	**391**	**(552)**	**943**
Total Reserves	6,726	(567)	0	(567)
Total Allocations	(1,509,043)	0	0	0
Other Corporate Income	(21,011)	0	0	0
Total Reported Position	**0**	**(176)**	**(552)**	**376**

Workforce Costs

The Health Board spent £56.8m on workforce in month 11 20/21. This is £9.2m more than the monthly average in 19/20 (£47.6m), of which c£1.1m relates to A4C wage awards and c£0.3m Medical & Dental wage awards.

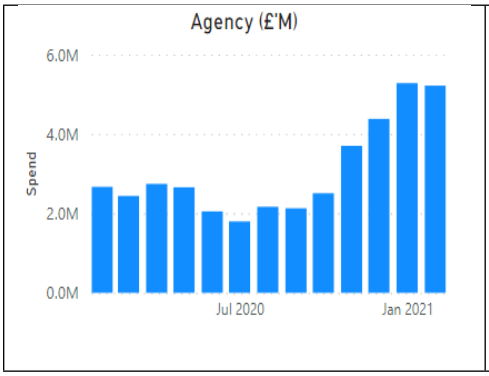


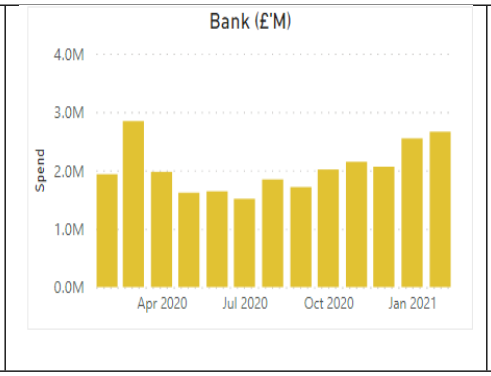
**excludes Pension Costs paid directly by WG and recharged in month12 (£22m 19/20)*
** Medical & Dental 20/21 Wage Award was paid in Oct 20, along with back pay to April 20

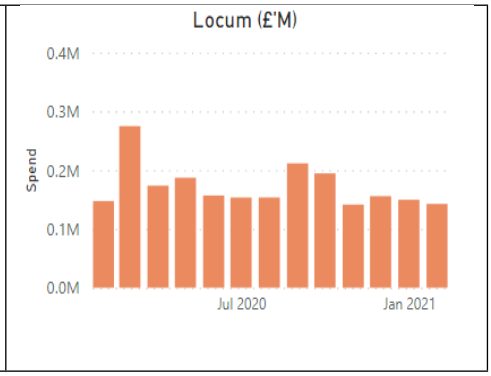
Variable Pay

Overall bank and agency expenditure increased during February 2021, increasing on the already elevated spend of January 2021. Total agency spend in month was £5.2m, a decrease in month of

1.2% compared to January 2021 and total bank spend was £2.6m in month 11 - an increase compared to January 2021 of 4.5%. Locum spend reduced slightly (4.7%), however, Retinue continue to report significant 'lost' savings from locums who are not using the Direct Engagement route. This expenditure can be seen from the graphs below.



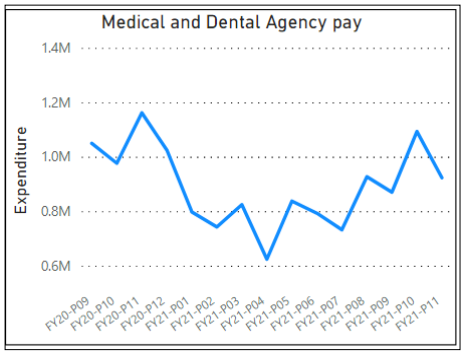


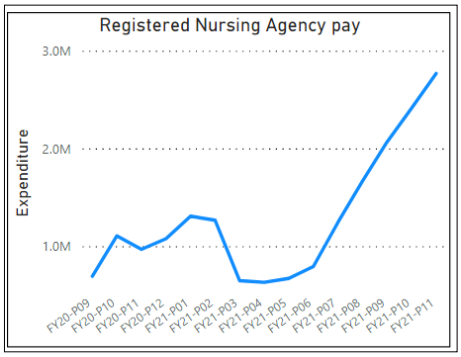


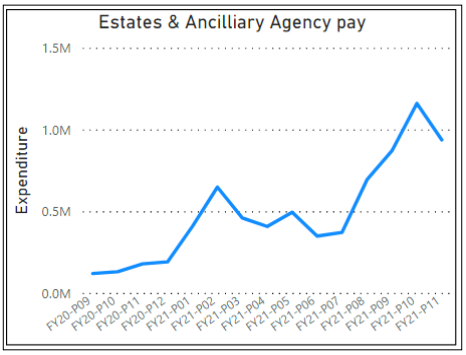
Agency:

The Health Board spent a total of £5.2m on agency staff in February 2021, £0.06m lower than the expenditure in January. Spend by categories of agency are:

- £0.9m on Medical Agency, this is a decrease compared to month 10 of £0.17m (average in 19/20 of £1m),
- £2.8m on Nurse Agency, an increase of £0.35m compared to month 10 (average in 19/20 of £0.85m),
- £0.9m on Estates & Ancillary, a decrease of £0.22m compared to month 10 (average in 19/20 of £0.13m),
- The balance of the agency is within A&C (£0.3m), Allied Health Professionals (£0.1m), HCSW (£0.1m) and Other (£0.08m)





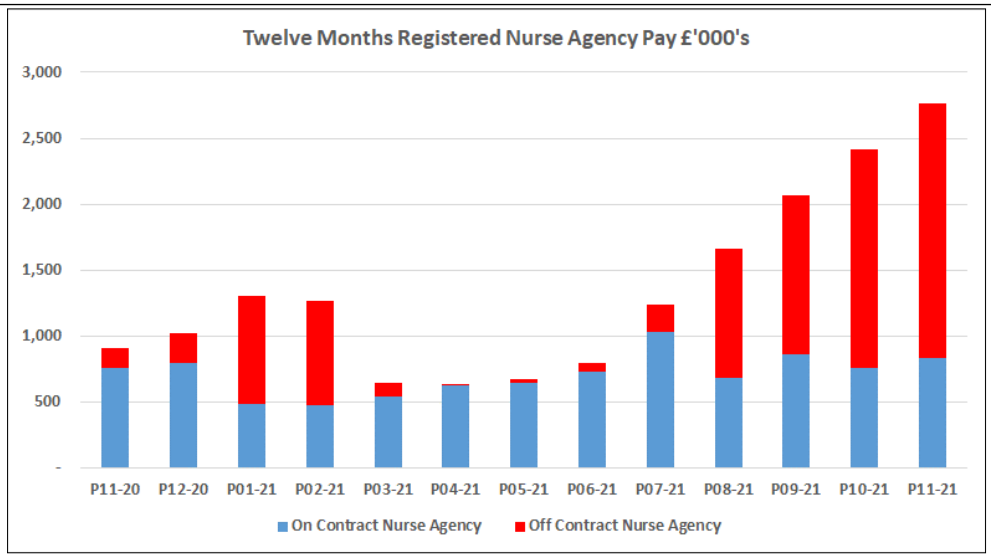


Registered Nurse Agency

Registered nurse agency expenditure has reached £15.5m year to date, total spend on this in 2019/20 was £10.2m. In 20/21 £7.7m of this spend is on the contractual framework (£9.5m full year 19/20) and £7.8m in 2020/21 not on a contractual framework (£0.65m full year 19/20).

Use of "off-contract" Registered Nurse Agency:

The Health Board has used £1.9m 'off-contract' registered nurse agency in February 2021; £1.9m higher than the average in 19/20 and £0.3m higher than January 2021. The spend on 'off contract' Registered Nurse agency is shown in the following graph.



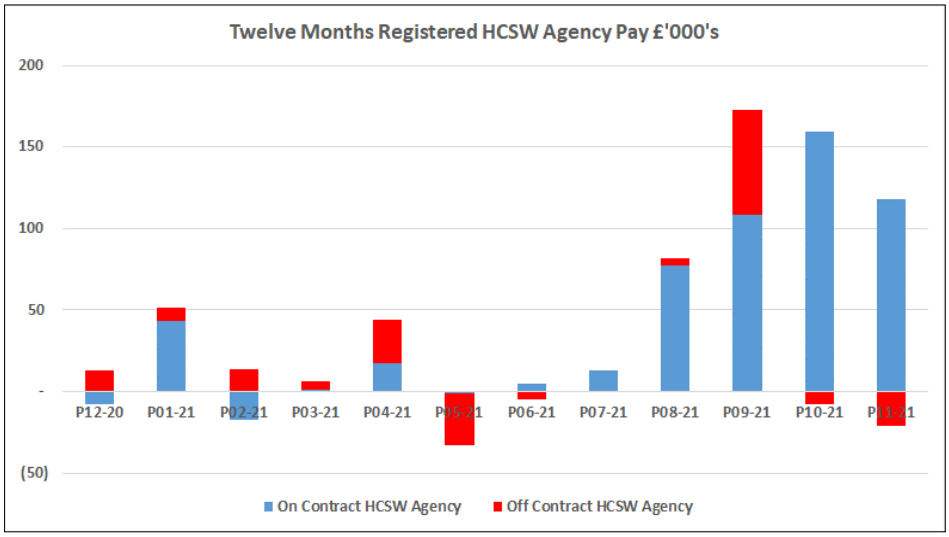
- Primary Care & Community (£66k): Cas-Gwent, St Woolos, YAB, County Community Hospital, YYF , Chepstow Community Hospital and Monnow Vale ward,
- Unscheduled Care (£1,078k); GUH (£530k), RGH (£260k), NHH (£289k). RGH has reduced from £322k spend in January 2021 and £284k in December 2020 due to the closure of wards/ beds.
- Mental Health & LD (£51k): various locations including PICU,
- Scheduled Care (£739k): various locations across, GUH (£521k) which includes £362k for GUH Critical Care, RGH (£181k), NHH (£32k), and YYF (£3k). Critical care off contract agency nursing continues to increase, and
- Family & Therapies (£1k): NHH Gynaecology.
- Therapies & Healthcare Scientists (£3k); Gwent wide Covid-19 testing.

The main reasons for requests to use 'off-contract' agency were:

- Significant nursing vacancies,
- Patient safety and enhanced care,
- Covid-19 responses / block booking, and
- Increased sickness and cover for staff shielding in roles related to direct patient care.

Consideration of maintaining safe services was the key factor in approving this cover.

The Health Board has used £97k HCSW total agency in February 2021; £78k higher than the average in 19/20 and £54k lower than January 2021. This month all HCSW agency was on contract of which £68k was in GUH and £44k in RGH.



The level of reliance on variable pay is a considerable risk for the Health Board as Covid-19 activity reduces and the Health Board implements its plans for 2021/22.

Drugs / Prescribing

The year-end forecast for prescribing reduced overall this month by £76k.

The December actual performance saw a small increase in item numbers and reduction in average item cost. Lower WP10HP's and Oxygen costs brought the forecast down.

The Covid-19 impact on additional prescribing spend is estimated to be circa £3.988m.

Referral to Treatment (RTT):

Elective activity has significantly reduced as part of the Health Board's Covid-19 planned response. Whilst some routine elective services have resumed, elective activity is still lower than pre-Covid-19 levels.

Elective Treatments (February 2021) :

- Increase compared to January. 1,049 (43%) of the planned 2,436 treatments for February were performed – this was in the specialties of Urology (370), General Surgery (230), Max Fax (154), Ophthalmology (132), Dermatology (125), and with limited numbers in ENT (32) and T&O (6).
- Year to date the treatments are 19,115 (70%) behind the pre-Covid-19 plan of 27,430.

Outpatients (February 2021):

- Increase compared to January. 3,233 (49%) of the planned 6,537 outpatient appointments for February were undertaken – this was in the specialties of General Surgery (815), Dermatology (746), Urology (375), Ophthalmology (318), T&O (300), ENT (293), Max Fax (271), and Rheumatology (115).
- Year to date the outpatients appointments are 39,829 (55%) behind the pre-Covid-19 plan of 72,314.

As a result of reduced elective activity, costs have been avoided and this has enabled some Covid-19 costs to be funded internally by the Health Board.

Diagnostics (February 2021):

- The Endoscopy diagnostics procedures delivered for the year to date are 10,606 (72%) of the planned 14,674.
- The following table illustrates monthly activity.

Endoscopy	Assumed YTD (M11) Activity	Actual YTD (M11) activity	Variance	% Undertaken
Apr-20	1,334	135	(1,199)	10%
May-20	1,334	942	(392)	71%
Jun-20	1,334	1,385	51	104%
Jul-20	1,334	375	(959)	28%
Aug-20	1,334	1,072	(262)	80%
Sep-20	1,334	1,320	(14)	99%
Oct-20	1,334	711	(623)	53%
Nov-20	1,334	1,178	(156)	88%
Dec-20	1,334	1,106	(228)	83%
Jan-21	1,334	1,114	(220)	84%
Feb-21	1,334	1,268	(66)	95%
Total year to da	**14,674**	**10,606**	**(4,068)**	**72%**

Outpatients:

- Medicine outpatient attendances undertaken for the year to date are 13,546 (51%) of the planned 26,411.
- Activity by Specialty is shown below;

Outpatients	Assumed YTD (M11) Activity	Actual YTD (M11) activity	Variance	% Undertaken
Gastroenterology	5,610	2,483	(3,127)	44%
Cardiology	6,083	3,755	(2,328)	62%
Respiratory (inc Sleep)	6,666	1,972	(4,694)	30%
Neurology	2,849	2,158	(691)	76%
Endocrinology	2,662	1,914	(748)	72%
COTE	2,541	1,264	(1,277)	50%
Total year to date	**26,411**	**13,546**	**(12,865)**	**51%**

With regard to Waiting List Initiative (WLI) Medical pay spend and activity:

Unscheduled Care Division have spent £95k:

- Gastroenterology (£63k): the number of endoscopy lists undertaken were 91 (90 in January) and nil gastro clinics (0 in January). Patients seen in February 2021 were 417 (415 in January)
- Cardiology (£32k) for 28 clinic sessions (25 in January) seeing 312 patients (300 in January), plus 15 Cath lab sessions treating 45 patients (6 sessions and 18 patients in January).

Scheduled Care Division have spent £66k:

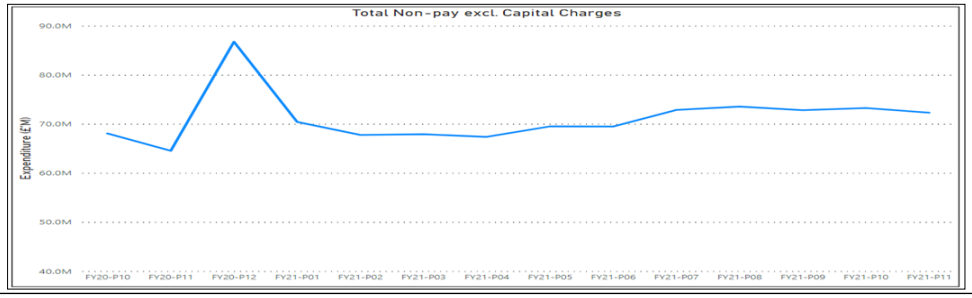
- Radiology (£55.8k): CT and MR reporting (£53k) and Ultra sound backlog sessions,
- Dermatology (£6.5k), backfill of vacancies, 5 treatments sessions and 4 outpatient sessions, and,
- Ophthalmology (£3k), Outpatients RTT.

Family & Therapies Division have spent £2.6k:

- ISCAN Neurodevelopmental - non-medical payments as part of an initiative to validate follow Up waiting lists with an aim to bring down the ISCAN Neurodevelopmental RTT numbers by 84 children in the last quarter of this financial year The plan is to spend c£11k in order to achieve this using WLI's for overtime at Serennu which should ensure that RTT is achieved at 80%.

Non Pay Costs.

Overall non-pay expenditure in month 11, excluding Capital Charges (£3m) was £72.3m which is a decrease of £1m compared to month 10, excluding Capital Charges. Adjusting for capital charges, the average non pay expenditure for the year to date is £70.6m, which is £3.1m above the average for 2019/20 (£67.5m).



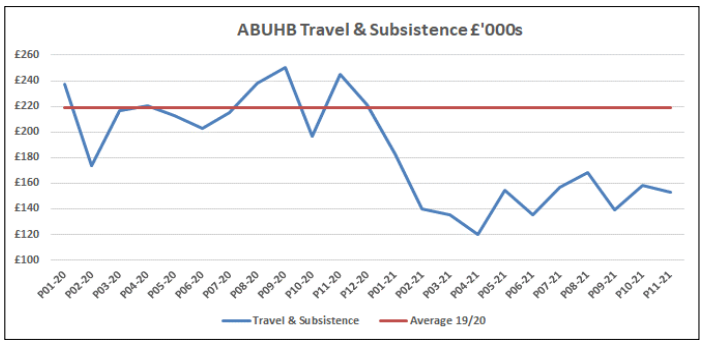
Adult CHC increased in comparison to recent months but patient numbers continue to show a reduced spend in comparison to earlier in the year. Adult CHC saw a reduction of 3 patients in February, to 501, increased patients allocated to Discharge to Assess (D2A) by 3 to 46 and FNC patient numbers have also increased by 10 to 753.

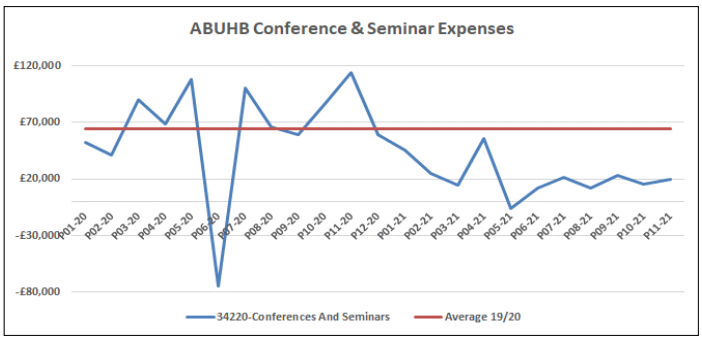
Mental Health CHC spend reflects a net 1 new Mental Health patient, 2 new high cost cases within Learning Disabilities.

Whilst costs have increased in a number of areas, due to Covid-19, some areas of expenditure relating to travel, training and conferences and seminars have decreased. Where changes in working practice, influenced by Covid-19, can be sustained this can be beneficial, both in terms of financial benefits and non-financial benefits (e.g. improved efficiency, reduced travel time and reduced carbon footprint).

The graphs below demonstrate that both travel & subsistence and conferences & seminars costs remain below the average for 2019/20.

- The Health Board's Travel & Subsistence expenditure is £766k lower when comparing months 1 to 11 of 20/21 with months 1 to 11 of 2019/20, and
- Conferences & Seminars expenses is £474k lower when comparing months 1 to 11 of 20/21 with months 1 to 11 of 2019/20.

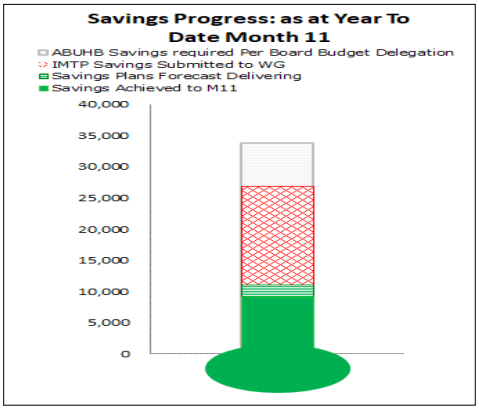




Savings delivery.

As part of the budget delegation, agreed in the March board, the Health Board's financial pan for 2020/21 identified a savings requirement of **£33.8m.**

Actual savings delivered to February amounted to £9.1m, forecast delivery for 2020/21 financial year is £11m (Green Schemes). The Health Board has therefore identified 33% of the original IMTP savings required.



As part of the Health Board's response to Covid-19, it is important that service changes which have achieved an improved patient outcome are continued (e.g. via greater use of technology to support remote delivery and alternative pathways of care). As the organisation starts to resume services, this provides an opportunity to improve outcomes for patients and make better use of resources. This is aligned with value based healthcare principles and enables the Health Board to be more flexible in delivering services, given the uncertainty that Covid-19 brings during the rest of the year and supports greater service sustainability in the future.

Revenue Reserves

The Health Board is holding in-year reserves for a small number of specific issues, in line with the budget delegations approved by the Board, these are awaiting final plans or start dates.

Description	20/21
Wage Award Pass through - HEIW	197,000
Financial Stability funding 20/21 - Committed to support decisions made to	547,664
Furniture + Fittings - RGH/NHH/Grange House	275,000
Lightfoot	250,000
Total Commitments	**1,689,664**

The Health Board is also holding specific funding allocations from Welsh Government in reserves, which will be allocated once plans or values have been finalised.

Welsh Government are expecting Health Boards and their partners to reprioritise uncommitted funding towards the Covid-19 response, where appropriate to do so. This funding may offer an opportunity to support the Covid-19 costs being incurred.

Risks & Opportunities

There remain several risks and opportunities during 2020/21, including:

- Covid-19 demand compared to Q4 plan - scale and timing of response and associated costs may vary with Q4 plans,
- Actual workforce costs compare operational plan assumptions,
- Non-delivery of savings,
- Continuing health care and prescribing spend,
- The opportunity to divert existing funding to support Covid-19,
- Treatment plans and associated costs – where elective services are resumed and/or reset,
- Welsh Risk Pool (WRP) contributions – these are not expected to change this year,
- The opportunity to make service improvements and cost efficiencies through MSK and Ophthalmology work streams (IMTP priorities),
- Opportunities from sustaining changed ways of working, including digital solutions and agile working arrangements,
- Opportunities for further slippage on projects, and

Scheme Pays – regularity issue

Whilst not considered a risk to delivering financial balance this year, the Health Board is undertaking work to identify potential tax liabilities, as a result of the Scheme Pays arrangements that were put in place following a Ministerial Direction issued on 18 December 2019. The Welsh

Government have taken action to support circumstances where pension / tax rules impact on clinical staff who want to work additional hours, and have determined that:
Clinical staff who are members of the NHS Pension Scheme and who, as a result of work undertaken in the 2020-21 tax year, face a tax charge on the growth of their NHS pension benefits, may opt to have this charge paid by the NHS Pension Scheme, with their pension reduced on retirement;
The Health Board will then pay them a corresponding amount on retirement, ensuring that they are fully compensated for the effect of the deduction.
This Scheme will be fully funded by the Welsh Government with no net cost to the Health Board. Clinical staff have until 31 July 2021 to opt for this scheme and the ability to make any changes up to 31 July 2024.

During the 2019-20 financial year, there was no evidence of take up of the scheme. However, should it emerge that there has been take up during the 2020-21 financial year, then the Health Board's external auditors – Audit Wales – may issue an opinion on the annual accounts identifying this expenditure as irregular.

Covid-19 – Revenue Financial Assessment

February forecast reporting is based on the Quarter 4 operational plan and the financial planning assumptions aligned with the plans.

Forecast costs can be broken down into the following categories:

	£m	£m
GUH – early availability/opening	21.5	
Other Covid-19 costs (e.g. PPE, beds, staff, TTP)	129.5	151
Savings non-delivery in 2020/21		22.7
		173.7
Operational costs not incurred	(40.8)	
Planned investments re-purposed	(10.4)	(51.2)
		122.5
Welsh Government funding (allocated and anticipated):		
Stabilisation funding (share of £371m)		70.4
Covid-19 allocations (received and anticipated)		52.1
		122.5

The Covid-19 Mass Vaccination Programme is continuing to develop in line with the plan, and a budget for the programme has been delegated to the Director of Public Health. The MVP forecast costs are £4.9m. Welsh Government has confirmed support for cost pressures arising from this programme.

The forecast cost of the Programme is currently at £4,910k, however uncertainty around the volume and timing of vaccine supply to the Health Board remains an issue, both in terms of delivery planning and financial forecasting. Activity for March is based on the anticipated supply of vaccines, and expected delivery channel i.e. Mass Vaccination Centre or GP Practice.

The Health Board and its' partners are expecting the contact tracing expenditure, matched by funding, to be £7.5m.

The Health Board is anticipating funding to offset the additional payments to Adult Social Care providers as directed by Welsh Government and funding to offset expenditure for the extended flu vaccinations.

The Health Board has estimated the value of untaken annual leave to be c£20.3m. Welsh Government have made revenue funding available and the Health Board has made financial provision on this basis.

2. Capital Performance:

The Capital Programme was approved by the Board in March 2020. The current approved resource limit is £111.194m with a year-end forecast of £111.849m. The adverse variance against plan of £0.655m relates to the currently unfunded costs associated with the acceleration of the Grange University Hospital opening (April and November acceleration costs) and the additional expenditure being incurred in relation to the Health Board's Covid-19 surge response across other sites. Welsh Government have confirmed this funding will be released in March 2021. The breakdown is set out in the table below:

Scheme	Forecast Expenditure £m	Confirmed Funding at M8 £m	AWCP Funding Shortfall £m
GUH Early Opening Acceleration (April & November)	9.300	9.090	0.210
Covid-19 Surge Funding	6.472	6.027	0.445
TOTAL	**15.772**	**15.117**	**0.655**

The forecast outturn against all the approved AWCP schemes have been further revised in month due to additional slippage against the Grange University Hospital and HSDU schemes. As the Capital Resource Limits for many of these schemes were fixed in November, any under / over spends need to be managed by the Health Board via brokerage arrangements i.e. Welsh Government have agreed that this slippage can be offset by bringing forward expenditure relating to planned 2021/22 AWCP schemes and the 2021/22 Discretionary Capital Programme allocation.

The Grange University Hospital post completion works are on-going such as the Dr's rest facilities, external path, road works, NICU parent bedroom scheme and storage facilities. In addition, the majority of the remaining equipment required has now been ordered and is expected to be delivered prior to the end of the financial year.

The HSDU scheme delay in relation to the endoscopy room works have resulted in additional 2020/21 slippage of £0.5m. All equipment expenditure has now been brought forward into the current financial year.

Of the £6.472m funding requested in relation to the Covid-19 essential building works and equipment requirements for the surge capacity at existing sites, £6.027m has been received to date. Welsh Government have confirmed that the final £0.445m will be released in March 2021. Additional funding has been confirmed in month in relation to the ventilators purchased by NWSSP earlier in the pandemic. These assets have now transferred to the Health Board's ownership.

Slippage of £0.343m has been notified against the ICF funded Rebound Facility at Serennu due to Covid-19 related planning delays. The brokerage required via the DCP to allow the funding to be carried forward to 2021/22 has been agreed by Welsh Government.

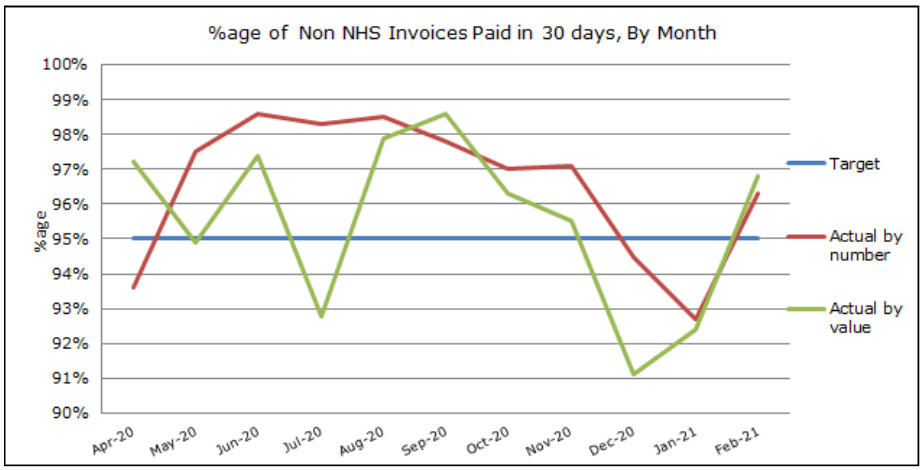
Additional funding has been received in month in relation to Digital Eye care equipment (£281k), devices for community nursing groups (£190k), Windows 10 upgrades to Imaging equipment (£242k) and the new Pharmacy system (£97k).

3. Cash Position

The cash balance at the 28th February is £3.290m, which is less than the advisory figure set by Welsh Government of £6m.

4. Public Sector Payment Policy (PSPP)

The HB are continuing to achieve the target to pay 95% of the number of non-NHS creditors within 30 days of delivery of goods on a cumulative basis.



Recommendation
The Finance, Audit & Risk Committee is asked to note: ➢ ***The financial performance at the end of February 2021 and forecast for 2020/21 – against the statutory revenue and capital resource limits,*** ➢ ***The revenue reserve position at the 28th February 2021,*** ➢ ***The Health Board's cash position and compliance with the public sector payment policy, and*** ➢ ***A financial assessment of the risks and opportunities impacting on the financial forecast for 2020/21.***

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Risks of achieving the Health Board's statutory financial duties and other financial targets are detailed within this paper.
Financial Assessment, including Value for Money	This paper provides details of the financial position of the Health Board as at Month 11 and the forecast position for 2020/21. It identifies the key financial risks and actions required to manage them.
Quality, Safety and Patient Experience Assessment	This paper links to AQF target 9 – to operate within available resources and maintain financial balance. This paper provides a financial assessment of the Health Board's delivery of its IMTP priorities and opportunities to improve efficiency and effectiveness.

Equality and Diversity Impact Assessment (including child impact assessment)	Not Applicable
Health and Care Standards	This paper links to Standard for Health services One – Governance and Assurance.
Link to Integrated Medium Term Plan/Corporate Objectives	This paper provides details of the financial position that supports the Health Board's 3 year plan. The Health Board has a statutory requirement to achieve financial balance over a rolling 3 year period.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term** **Integration** **Involvement** **Collaboration** **Prevention** The Health Board Financial Plan has been developed on the basis of the approved IMTP, which includes an assessment of how the plan complies with the Act.
Glossary of New Terms	See Appendix
Public Interest	Circulated to board members and available as a public document.

Glossary

A		
A&C – Administration & Clerical	A&E – Accident & Emergency	A4C - Agenda For Change
AME – (WG) Annually Managed Expenditure	AQF – Annual Quality Framework	AWCP – All Wales Capital Programme
B		
B/F – Brought Forward	BH – Bank Holiday	
C		
C&V – Cardiff and Vale	CAMHS – Child & Adolescent Mental Health Services	CCG – Clinical Commissioning Group
C/F – Carried Forward	CHC – Continuing Health Care	Commissioned Services – Services purchased external to ABUHB both within and outside Wales
COTE – Care of the Elderly	CRL – Capital Resource Limit	Category M – category of drugs
D		
DHR – Digital Health Record	DNA – Did Not Attend	DOSA – Day of Surgery Admission
E		
EASC – Emergency Ambulance Services Committee	EDCIMS – Emergency Department Clinical Information Management System	EoY – End of Year
ETTF – Enabling Through Technology Fund		
F		
F&T – Family & Therapies (Division)	FBC – Full Business Case	FNC – Funded Nursing Care
G		
GMS – General Medical Services	GP – General Practitioner	GWICES – Gwent Wide Integrated Community Equipment Service
GUH – Grange University Hospital		
H		
HCHS – Health Care & Hospital Services	HCSW – Health Care Support Worker	HIV – Human Immunodeficiency Virus

HSDU – Hospital Sterilisation and Disinfection Unit		
I		
IMTP – Integrated Medium Term Plan	IPTR – Individual Patient Treatment Referral	I&E – Income & Expenditure
L		
LoS – Length of Stay	LTA – Long Term Agreement	
M		
MH – Mental Health		
N		
NCN – Neighbourhood Care Network	NCSO – No Cheaper Stock Obtainable	NICE – National Institute for Clinical Excellence
NHH – Neville Hall Hospital	NWSSP – NHS Wales Shared Services Partnership	
O		
ODTC – Optometric Diagnostic and Treatment Centre		
P		
PAR – Prescribing Audit Report	PCN – Primary Care Networks (Primary Care Division)	PER – Prescribing Incentive Scheme
PICU – Psychiatric Intensive Care Unit	PrEP – Pre-exposure prophylaxis	PSNC –Pharmaceutical Services Negotiating Committee
PSPP – Public Sector Payment Policy	PCR – Patient Charges Revenue	PPE – Personal Protective Equipment
R		
RGH – Royal Gwent Hospital	RN – Registered Nursing	RRL – Revenue Resource Limit
RTT – Referral to Treatment		
S		
SCCC – Specialist Critical Care Centre	SCH – Scheduled Care Division	SCP – Service Change Plan (reference IMTP)
SLF – Straight Line Forecast	SpR – Specialist Registrar	
T		
TCS – Transforming Cancer Services (Velindre programme)	T&O – Trauma & Orthopaedics	

U		
UHB / HB – University Health Board / Health Board	USC – Unscheduled Care (Division)	
V		
VCCC – Velindre Cancer Care Centre		
W		
WET AMD – Wet age-related macular degeneration	WG – Welsh Government	WHC – Welsh Health Circular
WHSSC – Welsh Health Specialised Services Committee	WLI – Waiting List Initiative	WLIMS – Welsh Laboratory Information Management System
WRP – Welsh Risk Pool		
Y		
YAB – Ysbyty Aneurin Bevan	YTD – Year to date	

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit, Finance & Risk Committee Thursday 8th April 2021 Agenda Item: 5.2

Aneurin Bevan UHB Finance, Audit & Risk Committee

Savings & Efficiency Delivery 2021/22

Executive Summary

This paper sets out the savings programme for 2021/22 financial year and identifies:

1. Deliverable savings during the financial year,
2. Further savings opportunities, and
3. Delivery framework for implementing the Annual Plan and associated savings and efficiency programmes.

It is recognised that the Covid-19 pandemic has delayed the delivery of savings during 2020/21. The increased investment made in the GUH/e-LGH hospital network and non-delivery of savings has increased the requirement to deliver recurrent cash releasing savings, alongside re-allocating resources to improve health outcomes as local communities recover from the pandemic.

The 2021/22 Annual Plan identifies a recurrent saving requirement of c£33m (2.5%) to deliver financial balance. However, given the local investment plans proposed, it would be prudent to aim for a forecast saving requirement of **5%** recurrent over 3 years to support financial sustainability.

The Annual Plan includes an outline Delivery Framework for implementing the Health Board's priorities, although the detailed assurance and governance arrangements need finalising. The delivery of cash releasing savings, other efficiencies and re-allocating resources will be integral to delivering these priorities.

Delivery of the individual programmes and priorities will be managed through the Health System Leadership Board (Executive Board). Board assurance on individual savings and efficiency programmes will take place via the Finance, Audit & Risk Committee.

This paper sets out the current position on deliverable savings during the 21/22 financial year and further savings opportunities that can be delivered.

The Audit Committee is asked to note:

1. The deliverable savings during the 2021/22 financial year,
2. The further savings opportunities that can be delivered, and

3. The outline delivery framework for implementing the Annual Plan and associated savings and efficiency programmes.

The Finance, Audit & Risk Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	√
Note the Report for Information Only	

Executive Sponsor: Glyn Jones, Director of Finance & Performance			
Report Author: Rob Holcombe, Deputy Finance Director			
Report Received consideration and supported by :			
Executive Board	√	**Committee of the Board [Committee Name]**	
Date of the Report:			
Supplementary Papers Attached: Appendix 1 – Savings Scheme Scoping Brief Appendix 2 – ABUHB Efficiencies & Savings Delivery Pro-forma			

Purpose of the Report

This paper sets out the savings programme for 2021/22 financial year and identifies:

1. Deliverable savings during the financial year,
2. Further savings opportunities, and
3. Delivery framework for implementing the Annual Plan and associated savings and efficiency programmes.

Background and Context

The 2021/22 Annual Plan identifies a recurrent saving requirement of **c£33m (2.5%)** to deliver financial balance. However, based on existing investments made and future investments required, it would be reasonable to aim for a forecast saving requirement of at least **5%** recurrent over 3 years to support financial sustainability.

The Annual Plan includes an outline Delivery Framework for implementing the Health Board's priorities. The delivery of cash releasing savings, other efficiencies and re-allocating resources will be integral to delivering these priorities.

The delivery of recurrent savings is essential to support service and financial sustainability for the Health Board moving forward, including future investment in the Clinical Futures Strategy. The implications of responding to Covid-19 are likely to continue into the first half of 2021/22 financial. Nevertheless, there remain opportunities to make progress as routine services start to resume and recovery plans are developed and implemented.

In a 'normal' year, the traditional approach to savings in NHS Wales would expect to yield between 1-1.5% cash releasing savings annually (Health Foundation, 2016). In order to deliver savings of circa 2 to 3% required to implement the 2021/22 Annual Plan priorities a combined approach to savings and efficiency is necessary, including:

- Transactional – reducing costs of existing services/products,
- Variation – eliminating (unwarranted) variation in services,
- Improving productivity, and
- Service change/transformation – improving outcomes which matter to patients, redesigning care and re-allocating resources accordingly. This should result in making better use of resources.

Assessment and Conclusion

1. Deliverable savings 2021/22

Table 1 summarise the level of deliverable savings (green and amber) and an assessment of the opportunities available (red). These have been used to inform where it is reasonable to assume the delivery of the £33m savings required in order to set a balanced budget for the 2021/22 financial year and improve the underlying financial position.

Table 1 – Annual Plan Savings Programme 2021/22

Savings Tracker Summary	Cash-Releasing Saving	Cost Avoidance	Savings Total	Income Generation
£'000 (All Positive Entries)				
Planned Care	419	0	419	0
Unscheduled Care	0	510	510	0
Primary and Community Care (Excl Prescribing)	0	0	0	0
Mental Health	2,966	0	2,966	0
Clinical Support	52	0	52	0
Non Clinical Support (Facilities/Estates/Corporate)	3,138	0	3,138	0
Commissioning	0	0	0	0
Across Service Areas	0	0	0	0
CHC	638	0	638	0
Prescribing	502	0	502	0
Medicines Management (Secondary Care)	159	0	159	0
Green & Amber Sub-Total	7,874	510	8,384	0
Red Schemes	5,384	18,729	24,113	0
Grand Total	13,258	19,239	32,497	0

At March 2021, the Health Board is currently reporting deliverable savings of circa £8.4m, at this stage, predominantly within CHC, Facilities and Medicines Management programmes. They relate mainly to savings that would be regarded as transactional or reducing variation.

Table 2 summarises the currently quarterly profile of savings – identifying deliverable savings (amber / green) and opportunities which need to be implemented (red).

Table 2 - Quarterly profile forecast

Draft Scheme Profile	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Full Year
	£000	£000	£000	£000	£000
Green & Amber Sub-Total	1,506	1,848	2,317	2,714	8,384
Red Schemes	-	3,445	10,334	10,334	24,113
Total Quarterly	1,506	5,293	12,651	13,048	32,497

2. Further savings opportunities

There are significant further opportunities to deliver savings through service change / transformation and further reduction in (unwarranted) variation along with improving productivity of existing resources which will contribute to improved service delivery. Further progress will be essential in not only achieving financial balance in 2021/22 but in improving the underlying financial position.

The Health Board has an established Efficiency Opportunities Compendium tool - a shared resource which is continually updated, for Health Board budget holders and managers to use - which includes benchmarking and other business intelligence across the range of services provided. Intelligence is collated from a number of sources, including CHKS benchmarking data, Finance Delivery Unit (FDU) Efficiency Framework and good practice from the National Value & Efficiency Board. This is used to inform savings and other efficiency opportunities.

The Health Board's Annual Plan applies a patient care pathway approach to planning and delivering care, emphasising the importance of patient health outcomes and redesign of care and associated resources. Included within the 5 Annual Plan priorities are:

- Musculoskeletal (MSK),
- Eye care,
- Cancer,
- Child and adolescent mental health, and
- Outpatient care pathways
- Living Well, Living Longer (long term conditions)
- Improved efficiency in operating theatres and diagnostic services

There are many opportunities to improve the use and effectiveness of resources in these services, some of which are identified in Table 3. Making progress in scoping and implementing these change programmes will be key to delivering the Health Board's priorities and improving financial sustainability.

The significant investment, during 2020/21, in use of digital to provide patient and support services, should enable improvements in productivity and wider efficiency / cash releasing savings.

Table 3 – Opportunities (red) Schemes for 2021/22

Scheme	R/NR	£000	Description
Procurement	NR	1,560	Managing non-pay 1.2% inflation impact down across all budgets
WAST Intersite transport	R	1,000	Potential to reduce agreement following May 2021 review
GUH / ELGH fbc beds	R	2,924	Delivering bed plan saving to GUH FBC levels
Slippage in expenditure plans	NR	5,801	Potential slippage on new projects, CHC provisions and WHSSC projections
MSK	R	100	initial saving for 21/22 - potential £4m pathway benchmarked opportunity- links with outpatients/theatres
Eye care	R	100	initial saving for 21/22 - 20% of benchmarked opportunity - links with outpatients/theatres
Outpatients	R/NR	1,500	initial saving for 21/22 - 40% of potential benchmarked opportunity - links with digital schemes
Reducing Readmissions	R	100	initial saving for 21/22 - potential £2m benchmarked opportunity - links with theatres
DOSA	R	100	initial saving for 21/22 - 20% of potential benchmarked opportunity - links with theatres
Day case rates	R	200	initial saving for 21/22 - 50% of potnetial benchmarked opportunity - links with theatres
INNU	R	150	continued reduction of these exceptional cases
Value procurement	R	400	Linked to the clinical procurement opportunities for best patient outcomes
Value Lymphodaema	R	1,000	the estimated saving figure for ABUHB identified by the FDU and national programme
Care aims model skill mix	R	700	opportunities for multiple workforce efficiencies through a different skill mix and capacity model
Agile working	NR	200	underlying position - marginal step - excludes premises opportunity for 21/22
Digital enabled technology	R	1,000	new ways of working, eg. Flow system ALOS reductions and virtual outpatients
Miscellaneous corporate initiatives	NR	2,500	Workforce Agency/Sickness reductions through wellbeing initiatives (c.15% reduction on 20/21 agency spend)
Miscellaneous corporate initiatives	NR	300	Estates Rationalisation
Miscellaneous corporate initiatives	NR	100	Radiology/Diagnostics referral policies
Miscellaneous corporate initiatives	NR	350	Facilities Income generation
Miscellaneous corporate initiatives	NR	500	GUH investment performance improvement delivery
Miscellaneous corporate initiatives	NR	500	potential accountancy gains
Miscellaneous corporate initiatives	NR	228	corporate administrative savings
Miscellaneous corporate initiatives	NR	2800	general 0.2% CIP expectation across organisation

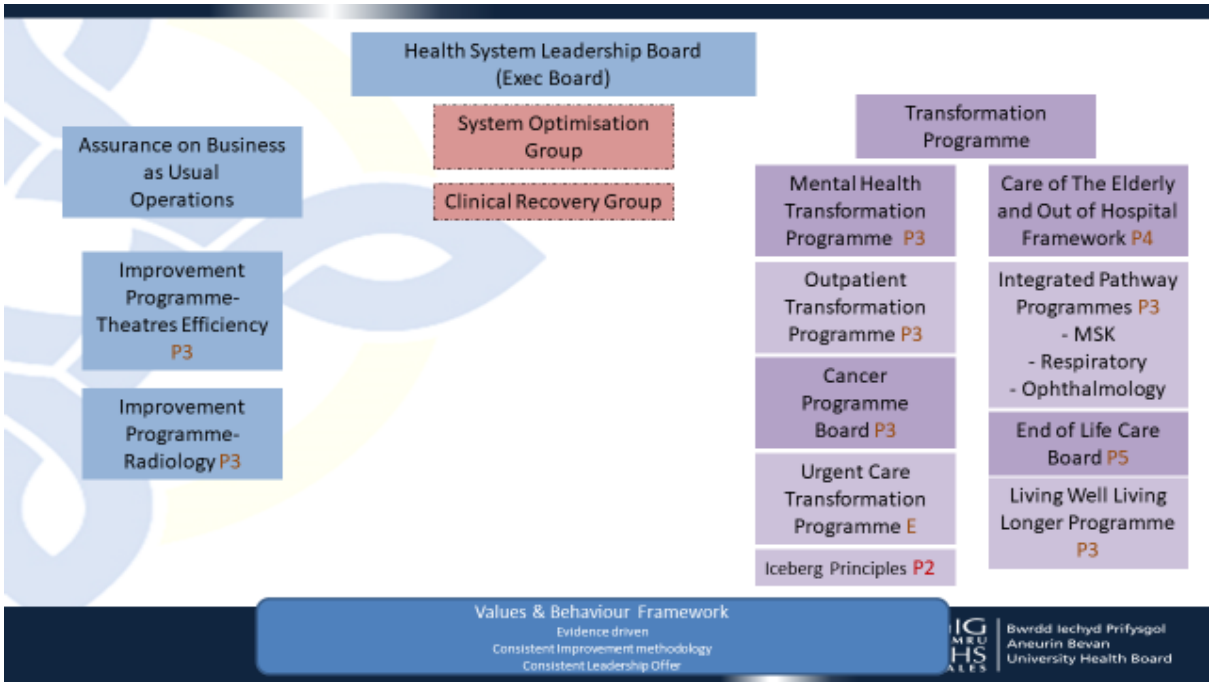
Further scoping of financial opportunities, indicates even greater savings and efficiencies can be achieved during this year and as part of a 3 year plan, including:

- Levering further bed reduction savings through full implementation of the wider Clinical Futures plans, circa 70 beds worth £2.5m
- Delivery of estates savings from Agile working, decarbonisation and premises rationalisation, potentially worth circa £1.5m,

- MSK pathway redesign – reduced demand on acute services and alternative pathways, potentially £4m compared to benchmarks; a 25% improvement worth £1m.
- Eye Care pathway redesign - reduce cost base by a further 10% £0.1m, avoid outsourcing £0.3m (non-rec).
- Outpatient transformation opportunity - reduce cost base by 10% or £1.5m,
- Medicines management - reduce waste & improve compliance, 1% change worth circa £1m.
- Full impact of adopting 'Care Aims' staffing model – reduced workforce costs, a further 10% reduction on Agency use worth £1m.

3. Delivery Framework

The Health System Leadership Board (Executive Board) will oversee the delivery of the Annual Plan priorities, including programme savings. This is illustrated in the following diagram. Appendix 1 provides further scheme details.



Formal programme management arrangements will be in place to monitor and review delivery of savings plans and report to the Health System Leadership Board. Assurance will also be provided, through the relevant committees, to the Board and this will include providing assurance on savings, efficiency and improved use of resources through the Finance, Audit & Risk Committee. The Committee's work programme for 2021/22 already includes a number of the priority programme areas.

The detailed assurance and governance approach needs to be finalised. However to align to best practice and improve and strengthen delivery the following needs to be established:

- PMO/Project management arrangements,
- Documented plans of action,
- Quantified – input/output/outcome measures,
- Clarity of which service budgets will be affected,
- Quality & Patient outcome impact assessments,

- Value based assessment,
- Monitoring & Reporting arrangements and
- Delivery timescales & accountability.

The assurance process should be simple and clear, using existing expertise and resource to focus on delivering the Annual Plan priorities. The process of delivering savings and efficiencies will be integrated with service and workforce planning and should not compromise quality and safety.

It will be important that the rigour applied in reviewing investment, dis-investment and re-investment of resources is maintained and strengthened within the new delivery arrangements – e.g. the role and function of the Pre Investment Panel (PIP) in evaluating service changes and impact on health outcomes and use of resources.

Appendix 2 and 3 provide examples of proforma that can be used in developing and monitoring the delivery of savings and other efficiency plans.

In conclusion, this paper has set out the current progress in identifying deliverable savings for the 2021/22 financial year and set out the range of savings opportunities that exist as part of implementing the Health Board's Annual Plan priorities.

Savings plans and opportunities of £33m are required to deliver financial balance during 2022/22 and recurrently, with deliverable savings of £8.4m being identified at this stage. The implementation of an effective Delivery Framework, as outlined in the Annual Plan, will be key to delivering on the Health Board's priorities including financial balance and ongoing sustainability.

Recommendation
The Finance, Audit & Risk Committee is asked to: 1. Deliverable savings during the financial year, 2. Further savings opportunities, and 3. Delivery framework for implementing the Annual Plan and associated savings and efficiency programmes.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The risks identified include: • Areas identified would either improve patient care or should not worsen outcomes for patients • The benefits of new systems should outweigh the costs incurred
Financial Assessment, including Value for Money	The target full year effect savings for each efficiency area is identified in the report. If savings are not achieved then investment decisions may need to be revisited to ensure financial balance.

Quality, Safety and Patient Experience Assessment	This paper links to AQF target 9 – to operate within available resources and maintain financial balance. Compliance with national guidelines. Each Savings plan lead will need to confirm and report any patient quality impact assessments.
Equality and Diversity Impact Assessment (including child impact assessment)	E&DIA should be performed where appropriate.
Health and Care Standards	This paper links to Standard for Health Services One – Governance & Assurance. Compliance with national guidelines.
Link to Integrated Medium Term Plan/Corporate Objectives	The IMTP explicitly requires efficiency savings to be made in order to deliver financial balance.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*This section should demonstrate how each of the '5 Ways of Working' will be demonstrated. This section should also outline how the proposal contributes to compliance with the Health Board's Well Being Objectives and should also indicate to which Objective(s) this area of activity is linked.*
	Long Term – yes
	Integration – yes
	Involvement – yes
	Collaboration – yes
	Prevention – yes
Glossary of New Terms	*This section should provide a definition of any new terms contained within the report*
Public Interest	*N/A*

Appendix 1 – Savings Schemes 2021/22

Division	Business Unit	Scheme / Opportunity Title	Recurrent (R) / Non Recurrent (NR)	Current Year Annual Plan £'000	Plan FYE (Recurring Schemes only) £'000	Date Scheme Expected to go Green	Scheme RAG rating (incl. Income Generation)
Unscheduled Care	N272 GUH ED	GUH ED Medical - Reduce variable pay	R	510	510	01-Apr-21	Amber
Scheduled Care	Scheduled Care	FOC Medicines	NR	48	0	01-Apr-21	Green
Scheduled Care	Scheduled Care	Epoetin - Homecare	NR	15	0	01-Apr-21	Green
Scheduled Care	Scheduled Care	Dasatinib – Homecare	NR	4	0	01-Apr-21	Green
Scheduled Care	Scheduled Care	Nilotinib – Homecare	NR	4	0	01-Apr-21	Green
Scheduled Care	Scheduled Care	Bosutinib - Homecare	NR	2	0	01-Apr-21	Green
Scheduled Care	Scheduled Care	Ibrutinib - Homecare	NR	13	0	01-Apr-21	Green
Scheduled Care	Scheduled Care	Clariscan to Dotarem Switch	NR	0	0	01-Apr-21	Green
Scheduled Care	Scheduled Care	Aflibercept discount	NR	40	0	01-Apr-21	Green
Scheduled Care	Scheduled Care	Azacitadine LOE	NR	10	0	01-Apr-21	Green
Scheduled Care	Scheduled Care	Chloramphenicol usage reduction	NR	2	0	01-Apr-21	Green
Scheduled Care	Scheduled Care	Daratumumab SC Switch	NR	6	0	01-Apr-21	Green
Scheduled Care	Scheduled Care	Amgevita contract discount	NR	9	0	01-Apr-21	Green
Scheduled Care	Scheduled Care	Inflectra contract discount	NR	2	0	01-Apr-21	Green
Scheduled Care	Scheduled Care	Kevzara Switch	NR	0	0	01-Apr-21	Green
Scheduled Care	Scheduled Care	Atovaquone	NR	5	0	01-Apr-21	Green
Complex Care	Community CHC & FNC	Reduction of RN Agency	R	102	139	01-Apr-21	Green
Complex Care	Community CHC & FNC	OT Therapy Hub	R	36	36	01-Jun-21	Amber
Complex Care	Community CHC & FNC	Accruals release (accountancy gains)	NR	500	0	01-Jun-21	Green
MH and Learning Disability	CHC Commissioning	CHC Eligibility Reviews	R	149	149	01-Jul-21	Amber
MH and Learning Disability	CHC Commissioning	CHC Repatriations to in house wards	R	579	579	01-Jul-21	Amber
MH and Learning Disability	CHC Commissioning	CHC Right Size Packages	R	127	127	01-Jul-21	Amber
MH and Learning Disability	CHC Commissioning	CHC Step Down	R	394	394	01-Jul-21	Amber
MH and Learning Disability	CHC Commissioning	CHC Change in Need	R	1,451	1,451	01-Jul-21	Amber
MH and Learning Disability	CHC Commissioning	Structured Clinical Management	R	266	266	01-Jul-21	Amber
Estates and Facilities	Estates and Facilities	Rates Rebates	NR	2,700	0	01-Jun-21	Green
Family & Therapies	Maternity Services	Maternity Information System	R	52	52	01-Jul-21	Green
Primary Care and Community	Primary Care and Community	Prescribing support dieticians (Prescribing)	R	200	200	01-Apr-21	Green
Primary Care and Community	Primary Care and Community	Waste reduction scheme (Prescribing)	R	75	75	01-Apr-21	Green
Primary Care and Community	Primary Care and Community	Pharmacy led savings (Prescribing)	R	50	50	01-Apr-21	Green
Primary Care and Community	Primary Care and Community	LOE (Prescribing)	R	27	27	01-Apr-21	Green
Primary Care and Community	Primary Care and Community	Scriptswitch (acute) (Prescribing)	R	150	150	01-Apr-21	Green
Scheduled Care	Theatres	Clinical Futures Theatres establishment	R	419	419	01-May-21	Amber
Estates & Facilities	Facilities	Clinical Futures non-pay savings	R	438	438	01-Oct-21	Amber
Central / TBD	All	Procurement	NR	1,560	0	01-Sep-21	Red
Central / TBD	Facilities	WAST Intersite transport	R	1,000	1000	01-Sep-21	Red
Central / TBD	Medicine & F&T	GUH / ELGH fbc beds	R	2,924	2924	01-Sep-21	Red
Central / TBD	Various	Slippage in expenditure plans	NR	5,801	0	01-Sep-21	Red
Central / TBD	Various	MSK	R	100	100	01-Sep-21	Red
Central / TBD	Various	Eye care	R	100	100	01-Sep-21	Red
Central / TBD	Various	Outpatients	R	750	750	01-Sep-21	Red
Central / TBD	Various	Reducing Readmissions	R	100	100	01-Sep-21	Red
Central / TBD	Various	DOSA	R	100	100	01-Sep-21	Red
Central / TBD	Various	Day case rates	R	200	200	01-Sep-21	Red
Central / TBD	Various	INNU	R	150	150	01-Sep-21	Red
Central / TBD	Various	Value procurement	R	400	400	01-Sep-21	Red
Central / TBD	Various	Value Lymphodaema	R	1,000	1000	01-Sep-21	Red
Central / TBD	Various	Care aims model skill mix	R	700	700	01-Sep-21	Red
Central / TBD	Various	Agile working	NR	200	0	01-Sep-21	Red
Central / TBD	Various	Digital enabled technology	R	1,000	1000	01-Sep-21	Red
Central / TBD	Various	Miscellaneous corporate initiatives	NR	7,278	0	01-Sep-21	Red
Central / TBD	Various	Outpatients	NR	750	0	01-Sep-21	Red

Appendix 2 - Savings Scheme Scoping Brief

Lead Executive: Lead Scheme Manager: Division/Dept:	

Description of Scheme & Action Points & Dates:

Total Savings expected in year	
Total Recurring Full year saving expected	
Profile of Delivery by month: April May June July August September October November December January February March	

Key Enablers required: Staff resources	
Financial support – Revenue	
Capital Funding (> £5k)	

Cross overs with other divisions agreed:	
Key decisions required to implement: what, by whom, by when	

Appendix 3

ABUHB Efficiencies & Savings Delivery Pro-Forma

ABUHB requires this pro-forma to be utilised as a benefits initiation, capture and reporting document and aims to promote the adherence to good practice. The purpose is to enable the sharing and recording of efficiencies and savings in ABUHB within Divisions and as an organisation. The completed pro-forma is to be maintained by the scheme lead who will be responsible for reporting to Executive Team. It will form part of the organisational reporting to Board and Executives and to Welsh Government. This pro-forma is to be completed for schemes > £25,000.

Executive Sponsor (s):			
Division (s):			
Scheme Lead: **Contact number:**			
Scheme Title:			
Speciality:		**Procurement support:**	
Scheme Finance support:		**Scheme Start Date:**	
Savings Category:		**SCP fit:**	
Scheme In Year benefit: (£):		**Scheme Full Year benefit: (£)**	

Scheme Type: (mark all appropriate)	Efficiency	Benchmarking	Procurement (& Name)	Service Modernisation	Transformation	Value	Guidance

Scheme Summary:
Start date:

Expected Fully implemented date:

Cross divisional impacts:

Stakeholder	Impact Metric	Impact £	Agreement?

Description and intention (What? & How?):

Benefits (Measurables/ Where?):

Risks and mitigating actions:

Baseline:

With financial & non-financial metrics & measures describe the current state (What? & Where?):

Change: (How?)

Outcome:
Using the same financial & non-financial metrics & measures describe the impact / outcome of the scheme (What? & Where?):

Measure / Metric	Baseline	Basis of Change: benchmarking / innovation…	Expected Change:	Expected Future State
e.g. LOS	10 beds Budget: £650k Current Spend: £700k	Innovation: improved recovery times	-1 bed -£55k	9 beds Revised expenditure: £645k
e.g. staff	Band 5: 30 W.T.E	Skill mix	Band 5: -6 W.T.E	Band 5: 24 W.T.E
e.g. drugs spend				
e.g. day surgery rates and number				

Scheme Timescales:
Key milestones, target dates with management actions and decisions required (Who? & When?)
(insert project plan if possible)

Reporting Route:
DMT
Exec Board

Financial Benefit:

Is there a Capital Impact?

Yes / No (delete as appropriate, if yes provide detail)

Financial Savings:

Year	£'000's	Cost Codes (s) For Spend Reductions
1 (insert year)	£	
2	£	
3	£	
4	£	
5+	£	

Expected Savings Profile:

£'000's	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	Total
Year 1													
Year 2													

Basis of the Calculation: **This will be measured Monthly by (How? Where?):**	Year 3 Year 4 Year 5+
Is it Cash Releasing?	Yes / No (delete as appropriate, if no provide detail if cost avoidance / other efficiencies or VFM)
Does the scheme require any initial investment?	Yes / No (delete as appropriate, if yes provide detail of £ and how it will be funded)

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Audit, Finance & Risk Committee Recommendations – to the end of March 2021

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit, Finance & Risk Committee Thursday, 8th April 2021 Agenda Item: 6.1

Aneurin Bevan University Health Board

High Level Audit Recommendations Tracker

Executive Summary

This report provides the Audit Committee with an update on the progress with the audit tracker.

This report provides information on the current status of the recommendations following review by the Executive leads. The tracker indicates those recommendations in the opinion of the Executive Team that have been completed and are proposed to be taken off the tracker, those that have made significant progress, but are still not fully complete and those where some progress has been made, but a number of factors still remain which prevents the action being fully completed.

The Committee will note that it is proposed that one item (100) is marked as complete and to be removed from the tracker.

Recommendation 100 – the Health Board will update its ICT disaster recovery plans and test these to ensure they work as intended.

The work being undertaken by Informatics around the Network and Information Systems (NIS) Directive provides assurances about the security controls and plans for improving controls. These supersede the audit tracker requirements and it is recommended that this can be marked as complete and removed from the Tracker.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Audit, Finance & Risk Committee Recommendations – to the end of March 2021

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
20. (IA)	Clinical Audit *May 2017*	**R3** An effective mechanism for the identification and follow-up of actions arising from a clinical audit undertaken locally and nationally, should be implemented as soon as possible, in order to provide assurance that effective action is being undertaken to mitigate clinical risk.	November 2017	Medical Director	**September 2019 Update:** A Clinical Effectiveness Group has been set up which is the vehicle for taking forward the recommendations in relation to the three levels of Clinical Audit. The Quality Improvement and Leaders Group is overseeing the development of the Quality Improvement Strategy and Assurance Framework, which will then allow the assessment of the level of clinical of clinical audit required to take forward the strategy. The identified date for completion is June 2020. **November 2019 Update:** Implementation of the agreed Action Plan continues in line with agreed timelines. Update being provided to the Quality and Patient Safety Committee at its December Meeting. **January 2020 Update:** Reassurance received from the Chair of Clinical Effectiveness Group regarding Audit Dashboard being managed and completed. Instruction regarding clear trail of feedback to Clinical teams on Manager section required. **April 2020 Update:** No further update due to COVID - the program of national clinical audit has been suspended. **June 2020 Update:** The National Clinical Audit and Outcomes Review programme was stood down in March 2020 as a result of COVID and as a result reporting of national audits has ceased. The Clinical Effectiveness Group has not sat since the onset of COVID but will be reinstated by August	**Action required to achieve - green/completed status:** Progress has been made with an action plan in place and groups actively working to complete this plan. Evidence of some elements being complete however, assessed as amber as the action plan will not be fully complete until June 2021.

Audit, Finance & Risk Committee Recommendations – to the end of March 2021

					2020. The priority for CEG once restarted will be: • Monitoring of progress against identified improvement actions associated with National Clinical Audits • Identification of exceptional performance • Exception reporting through QPSOG **October 2020 Update:** National Audits have recently started to be published again following a cessation of HQIP activity over the peak COVID period. The clinical effectiveness and standards group will reconvene in early December 2020 to provide oversight and assurance around National Clinical Audits and to progress the action plan. The Medical Director is in the process of strengthening organisational processes to support individual reflection and learning from clinical audit data. **November 2020:** National Audits have recently started to be published again following a cessation of HQIP activity over the peak COVID period. The Clinical Effectiveness and Standards group will reconvene in early December 2020 to provide oversight and assurance around National Clinical Audits and to progress the action plan. The Medical Director is in the process of strengthening organisational processes to support individual reflection and learning from clinical audit data. **January 2021 Update:** An Update of all existing actions associated with national audit will be presented to the Clinical Standards and Effectiveness group in February 2021. Divisional oversight of National Audit results and recommendation will be strengthened through regular meetings between the QPS team and the Divisions. **March 2021 Update:** Reporting of the National Clinical Audit and Outcome Review Programme was impacted significantly by COVID from March 2020 with many national reports being delayed	

Audit, Finance & Risk Committee Recommendations – to the end of March 2021

					and Welsh Government requirements to report actions to them relaxed. Reporting of annual reports resumed in the autumn but reporting to WG remains on hold. Internal governance arrangements around scrutiny of national audits has continued with clinical audit leads reviewing results and identifying requisite actions. The Health Board participates in all relevant National Clinical Audits with the exception of the Cardiac Rhythm Audit. Work is underway with the Cardiology Directorate to understand the constraints and progress data collection. The Clinical standards and Effectiveness Group resumed in February 2021 and is integral in ensuring that Divisions have ownership of audit outcomes and are central to the development and monitoring of actions and improvements. The Clinical Standards and effectiveness group reports into QPSC via QPSOG. Reporting of national clinical audit to the Board has strengthened since June 2020 with audit results now included in every QPSC performance report. Ongoing reporting arrangements are being considered by the Executive Team in conjunction with the Chair of the QPSC committee to ensure further visibility of audit results and requisite improvement considering the Duty of Quality.	

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Audit, Finance & Risk Committee Recommendations – to the end of March 2021

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
77 (IA)	Structured Assessment *2017*	**R4 Internal control** The Health Board should ensure that clinical audits provide assurance within an assurance framework, linked to the organisation's strategic objectives	End of May 2018	Medical Director	**September 2019 Update:** A Clinical Effectiveness Group has been set up which is the vehicle for taking forward the recommendations in relation to the three levels of Clinical Audit. The Quality Improvement and Leaders Group is overseeing the development of the Quality Improvement Strategy and Assurance Framework, which will then allow the assessment of the level of clinical of clinical audit required to take forward the strategy. The identified date for completion is June 2020. **November 2019 Update:** Implementation of the agreed Action Plan continues in line with agreed timelines. Update being provided to the Quality and Patient Safety Committee at its December Meeting. **January 2020 Update:** Implementation of the agreed Action Plan continues in line with agreed timescales. **April 2020 Update:** No further update due to COVID. **June 2020 Update:** The Quality Assurance Framework was published in March 2020 which incorporates a structure to oversee the governance framework of the health and care standards. As the Framework is implemented it will support the appropriate oversight and assurance around the results and the necessary improvements identified in each of the National Audits. The Clinical Audit dashboard is maintained and includes identified improvement action and follow-ups.	**Action required to achieve - green/completed status:** Progress has been made with an action plan in place and groups actively working to complete this plan. Evidence of some elements being complete however, assessed as amber as the action plan will not be fully complete until June 2021

Audit, Finance & Risk Committee Recommendations – to the end of March 2021

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
					October 2020 Update: The Clinical Audit dashboard continues to be maintained. A framework for further strengthening assurance to the board on quality management including clinical audit will be presented to the QPSC Board Committee at its November meeting. **November 2020:** Work is underway to map all health and care standards to groups and committees across the health board and to align to policies and procedures. Work will then be undertake to establish what audit is undertaken to provide assurance around these standards. A corporate audit plan is being developed to ensure progress this prudent approach to corporate audit. An initial report will be presented to February 2021 QPSC. **January 2021 Update:** Work to map the requirement for ongoing local audit or the development of additional local audits to provide assurance around the Health and Care Standards and in line with the Quality Assurance Framework is ongoing. A discreet programme of local health Board wide audit is in place for 2021/22 but it is expected that this will continue to evolve throughout the year to respond to emerging quality and Safety priorities. **March 2021 Update:** The clinical audit strategy and policy are in date but due for review in 2021. This work will be completed by June 2021 and will reinforce a 3 tiered process of audit that will provide assurance. Tier 1 – National clinical audit	

Audit, Finance & Risk Committee Recommendations – to the end of March 2021

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
					Tier 2 – Local audit design to provide assurance around quality and patient safety priorities Tier 3 – clinical audit undertaken for any other reason including education / development. Opportunities to involve trainees in tier 2 audits and health board governance and quality improvement programmes associated with these audits will be explored with the Medical Education Team. IT systems to support a Health Board approach to oversight and scrutiny and improvement of clinical audit work will be considered in 2021, with a view to procuring / developing a system. The system will be key in the tracking of actions and improvements arising from clinical audit. 4 key quality and patient safety priorities have been identified in the 2021/2024 IMTP • Safety Culture • Data for quality and improvement • Learning organisation • Just Culture Safety Culture will involve a review of the assurance function of groups and committees across the health board and a review of the quality and safety structures across all divisions and directorates to ensure clear lines of responsibility accountability escalation and assurance. Assurance around clinical audit will be an important part of this workstream.	

Audit, Finance & Risk Committee Recommendations – to the end of March 2021

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
					Data for quality and improvement will involve developing the capability and capacity within directorates and divisions to understand and utilise data including clinical audit results.	

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Audit, Finance & Risk Committee Recommendations – to the end of March 2021

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
88 (IA)	IT Service Management	**R3** Informatics should seek to develop a SKMS in order to share knowledge across departments. This process should include developing a Knowledge Centred Service (KCS) process within the service desks and ensuring models for calls and problems are catalogued and indexed and easily available.	October 2018	Director of Planning, Digital and IT	**September 2019 Update:** National standards for classification, prioritisation and service level targets/metrics have been adopted and are reported at ICT monthly management board. **November 2019 Update:** Requirements for SKMS have been identified and agreed, awaiting funding to develop revised share point. Content has started to be collated in terms of: • Policies and procedures • Knowledge articles • Post Incident Review reports • Operational Performance reports • Minutes from CAB meetings • Minutes from supplier review meetings With regards KCS process- a review of services and related predefined templates for service desk tickets has been commenced. **January 2020 Update:** The above information continues to be captured and made available using existing tools. Initial meeting with 3rd party Red Cortex scheduled for 14th January to agree scope for requirements gathering for revised Share Point, on which SKMS will be developed, based on KCS principles and concepts. Actions arising from post incident reviews to improve service quality are being recorded, tracked and implemented. In addition post incident reviews are being reviewed to identify how/when issues are reported to IGC and under NISD regulations to Welsh Government.	**Action required to achieve - green/completed status:** To be reviewed post COVID. Progress is still being made. Path to green has been identified. However, recommend that this remains amber at this stage and will be reported further post March 2021.

Audit, Finance & Risk Committee Recommendations – to the end of March 2021

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
					April 2020 Update: No change – COVID work prioritised. **June 2020 Update:** No change – COVID work prioritised, currently engaging with Execs on resources required to continue with COVID priorities and complete this work package. **October 2020:** Further involvement from Red Cortex was discounted on cost grounds. A knowledge management workshop was held in August to introduce the concepts and a project is now running to a) discover information we hold, b) carry out gap analysis and c) options to mitigate risk. SharePoint online is under review to provide full SKMS but basic SKMS to be available by year end using MS Teams as a temporary SKMS until SharePoint version completed. **Executive Team Update – November 2020:** A SharePoint specialist has now been appointed as part of the Office 365 programme. Once the deployment of O365 has been completed capacity will be available to develop. **January 2021 Update:** The need to focus on the technical migration to office 365 to support the digital transformation required in response to the pandemic has meant that this work has progressed slowly. It is unlikely that we will make any significant progress before April 2021. **March 2021 Update:** The need to focus on the technical migration to Office 365 to support the digital transformation required in response to the pandemic has meant that this work has	

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Audit, Finance & Risk Committee Recommendations – to the end of March 2021

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
					progressed slowly. Further progress will be made on this from April 2021.	

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Audit, Finance & Risk Committee Recommendations – to the end of March 2021

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
99a (AW)	Structured Assessment 2018	**R3 - Information Governance** • The Health Board should improve its information governance arrangements by: • improving compliance with the information governance training programme to reach the national rate of 95%;	March 2020	Director of Planning, Digital and IT	**September 2019 Update:** IGU now undertake the updating of staff training on ESR. We experience challenges in placing ABUHB e learning on to the NHS Wales ESR – staff currently have to log in vis the ABUHB intranet. This affects compliance rates. The Health Board look to Director WOD to request ABUHB links on ESR. SIRO training arranged for September 2019. Believe that achievement of 95% compliance is ambitious when absence is taking in account. Initial target which is perceived as achievable is 90%. **November 2019 Update:** SIRO training undertaken. Clarity has been sought about the national target and compliance rates. The NHS Wales IG Management Advisory Group (IGMAG) members consider that the Welsh Government target is 85%. This will be addressed through NHS Wales IGMAG. **January 2020 Update:** IGMAG considered target as 85%. Current ABUHB rate as of Dec 2019 is 71%. **April 2020 Update:** No change – COVID work prioritised, however, training completeness rate has increased to 72%. **June 2020 Update:** Increase in training compliance to 75% however, COVID work has been prioritised. **October 2020 Update:** No change COVID prioritised but staff continue to undertake training and IGDG's are main mechanism to promote training needs.	**Action required to achieve - green/completed status:** To be reviewed post COVID This has now been assessed as amber, further work being undertaken to be clear what needs to be done to achieve the 95% target and how achievable this is as a target?

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Audit, Finance & Risk Committee Recommendations – to the end of March 2021

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
					Executive Team Update – November 2020: The Head of Information Governance and Data Protection Officer has been appointed to the post of Interim Board Secretary. Work is now underway to appoint an interim lead. COVID priorities have depleted the team. Training compliance has fallen to 70% which is expected. **January 2021 Update:** Increase in training compliance to 76%. IGDG's are currently suspended due to COVID, however when the new Head of IG & DPO is appointed it is intended that a review is undertaken of the IG training strategy to assist in improving compliance. **March 2021 Update**: IGDGs remain suspended but planning has commenced to reinstigate Q1 2021/22. This is dependent on Health Board staff availability etc and subject to any other surge/activity.	

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Audit, Finance & Risk Committee Recommendations – to the end of March 2021

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
100	Structured Assessment 2018	• updating its ICT disaster recovery plans and test these to ensure they work as intended.	March 2020	Director of Planning, Digital and IT	Work is ongoing with the newly recruited team in compliance with NISD. A Task and Finish group is currently prioritising and planning continuity arrangements led by the Emergency Planning Team. Infrastructure level failover and failback of 81 systems was undertaken in April/May 2019 respectively. Specific application testing and evaluation of this is an on-going task. **September 2019 Update:** Cyber Security Team operating model. The system availability testing continues and ICT DR plan is under development. **November 2019 Update:** Further testing and development as outlined above continues. **January 2020 Update:** Received Internal Audit report of BCP Jan 2020; provides the Health Board with Reasonable Assurance. A management response will be issued before the end of January with timescales for the recommendations to be completed. **April 2020 Update:** No change – COVID work prioritised. **June 2020 Update:** No change – COVID work prioritised, currently engaging with Executives on resources required to continue with COVID priorities and complete the work package.	**Action required to achieve - green/completed status:** To be reviewed monthly as Post COVID recovery continues.

Audit, Finance & Risk Committee Recommendations – to the end of March 2021

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
					October 2020 Update: Informatics has confidence in the high availability of the systems and applications it manages directly, however, it has not been able to focus on assurances i.e. testing of BCP, as its priorities have been moved to ensuring GUH opening and COVID response. **November 2020 Update:** GUH early opening has prevented progress. **January 2021 Update:** GUH early opening has prevented progress. There have been a number of critical BAU and environment tasks that have been picked up following GUH early opening. The team has a new line manager and they are keen to make progress in gaining control of the workload and ensuring that these assurance activities are undertaken. As per the status, the team has not been able to progress significantly as we are not presently "post COVID". **March 2021 Update**: Work has now commenced again following re prioritisation following COVID phase and successful recruitment in the cyber security team. ABUHB along with DHCW WG are part of a national NISD adoption with the cyber unit in DHCW being nominated as "Competent Authority" as part of the new SHA. The work being undertaken by Informatics around the Network and Information Systems (NIS) Directive provides assurances about the	

					security controls and plans for improving controls. These supersede the audit tracker requirements and it is recommended that this can be marked as complete and removed from the Tracker.	

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Audit, Finance & Risk Committee Recommendations – to the end of March 2021

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
112 (IA)	Job Planning	The Health Board should: • review the escalation process to ensure that it includes appropriate action following escalation to the Medical Director and holds medical staff to account for failure to have an in date job plan; • produce action plans to address poor compliance and review these as part of the monthly divisional meetings with the COO; • complete job plans on an annual basis, as opposed to a 15-month cycle. • consider the process for reviewing job plans and look at ways of increasing compliance, such as aligning job planning dates with other activities (i.e. IMTP /Corporate Planning cycle); and; • ensure that divisions and directorates have a process in place for a formal meeting with the consultant / SAS doctor in order to	March 2020	Medical Director	**June 2020 Update:** Divisional Directors have been written to with the findings of the internal audit. An escalation process has restarted (temporarily deferred during COVID surge). The Escalation tracker being maintained. A detailed tracker is being developed with Divisions to get GUH-critical job planning undertaken in advance of opening, against agreed service plans. **October 2020 Update:** A detailed tracker of progress of service/team/individual job planning for GUH-affected job plans at a directorate level has been developed and is reported monthly to the Executive Team. **Executive Team Update – November 2020:** Monthly tracker of Divisional job planning position continues to be reported at Executive Team. **March 2021 Update**: Monthly tracker of Divisional job planning position continues to be reported at Executive Team. A paper will be presented to the Board in April outlining the plan and approach to improve job planning compliance and ensure job planning is linked to service requirements and delivery. This will include:- • the procurement and implementation of e-job planning and e-rostering systems. This approach was agreed by the Executive team on 15th March 2021. *Timeline for implementation to be confirmed as part of the procurement exercise.*	**Action required to achieve - green/completed status:** Current status is amber to reflect current progress. Pathway to green identified by May 2021.

		agree the job plan and implement an escalation / disciplinary process if there is not a legitimate reason for failure to agree a job plan.			• revising and updating the job –planning escalation process prior to re-launch post COVID activity. Making clear the consequence of non-engagement – *In place May 2021*. • introduction of a ABUHB job planning procedure aligned to the all Wales Effective Job planning guidance to ensure consistency of approach across the divisions and specialities eg SPA allocation- *In place May 2021.* • development of a standard operating procedure for Team Job Planning • engagement of directorate management teams - *In Place May 2021.*	

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Audit, Finance & Risk Committee Recommendations – to the end of March 2021

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
114 (IA)	Patient Experience (PREMS)	1.1 The review of the effectiveness of the PEC should be completed and implemented. 1.2 The Health Board should develop a strategic approach to reporting on all aspects of patient experience and person-centred care (including PREMS), for example, through an integrated patient experience report that clearly links to the Health Board's strategy. Patient experience reports (including PREMS) should regularly feature on the QPSC forward work programme.	September 2020	Director of Nursing	Agree **October 2020 Update:** Patient Experience is a key element of the QPSOG Divisional reporting and there is a general view that a separate committee is not prudent. A specific Patient Experience Report has been prepared for the QPSC and will be a standing agenda item moving forward, which was positively received. There are on-going discussions about an electronic PREM but in the meantime paper-based approaches are continuing. **November 2020 update:** No update. To be considered by end of December 2020. **January 2021 Update:** See status update. **March 2021 Update**: No change.	**Action required to achieve - green/completed status:** Remains an amber due to the pandemic and electronic reporting system. To note: as part of the "once for Wales concerns management system" there is functionality for patient experience user feedback system to be procured. The ADON – Person Centred Care Team is leading this work stream with Informatics Team. A clearer position will be available by April 2021.

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit, Finance & Risk Committee Thursday 8th April 2021 Agenda Item: 6.2

Aneurin Bevan University Health Board

REVISED RISK MANAGEMENT APPROACH AND DELIVERY FRAMEWORK

Purpose of the Report			
The purpose of this report is to request endorsement from the Audit Committee to adopt the revised approach and delivery framework for the management of risk acknowledging that further refinement and development will take place to complement and enhance assurances within the Board Assurance Framework.			
The Board is asked to: (please tick as appropriate)			
Approve the Report			**X**
Discuss and Provide Views			**X**
Receive the Report for Assurance/Compliance			
Note the Report for Information Only			
Executive Sponsor: Richard Howells, Interim Board Secretary			
Report Author: Danielle O'Leary, Head of Corporate Services, Risk and Assurance			
Report Received consideration and supported by :			
Executive Team	**x**	**Committee of the Board [Audit Committee]**	
Date of the Report: 12th March 2021			
Supplementary Papers Attached: Appendix 1 – Risk Management Delivery Framework			

Executive Summary

This report sets out the revised risk management approach for the Health Board, describing how risks will be identified, tracked, monitored and embedded throughout the Health Board. Audit Committee is requested to endorse this approach.

The Health Board has previously received recommendations about its risk management approach by Internal Audit and Audit Wales; essentially recognising that improvements were needed. Work with the Executive Team further acknowledged that changes in the way in which the Health Board manages its risks was required.

It is anticipated that the revised approach will strengthen links to operational risk and translate them to high level strategic themes. In endorsing this approach, the Health Board will position itself to further become a population focussed Health Board tackling health inequalities and adopt an outward facing approach to strategic risk management.

Background and Context

Over the last three years the Health Board has been subject to various assessments regarding its corporate risk management function through Internal Audit, Audit Wales and the Health Board's own internal assessments. In 2019 the Health Board received a reasonable assurance rating from Internal Audit in respect of risk management and subsequently in 2020 received a limited assurance from Internal Audit. A number of recommendations were put forward (as part of the Audit Wales Structured Assessment and Internal Audit recommendations) and an action plan was agreed. In 2019/20 work was undertaken to further refine the corporate risk framework and Board Assurance Framework (BAF) however, it was acknowledged that further work should be undertaken to enhance the already well established risk management mechanisms and governance arrangements. The Health Board has recognised the requirement for risk management to be better resourced and subsequently made an appointment to provide dedicated support to take the risk management agenda forward. The newly appointed Head of Corporate Services, Risk and Assurance has been in post since 1st February 2021.

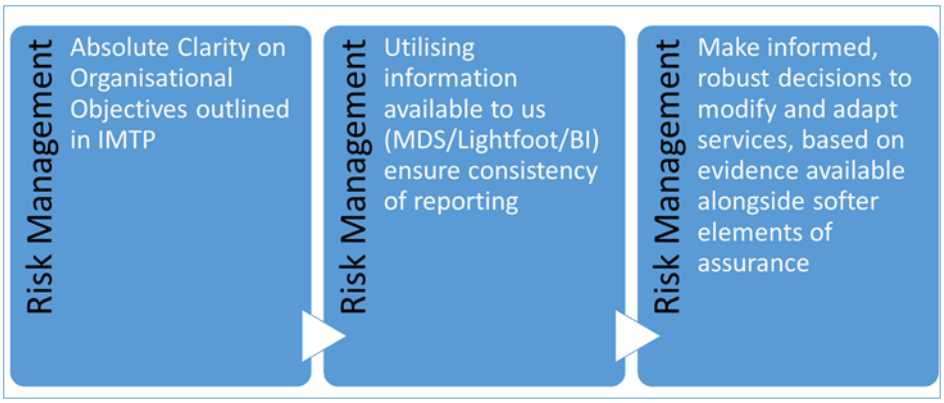
During February 2021, the Executive Team participated in three development sessions focussed on risk. These development sessions enabled the Executive Team to:

- Receive and verbally endorse the revised risk approach
- Agree to a broad set of strategic themes

  (although these will be subject to change as operational risks are brought through and thematic analysis undertaken)
- Agree the definitions of actions to be undertaken for each risk (i.e. Tolerate, Treat, Terminate, Transfer),
- Agree a set of definitions against risk appetite levels

  and
- Review the current principle risks on the Corporate and COVID risk registers.

The Executive Team also agreed the proposed foundation of high level assurance flows in relation to risk management which is outlined below:



Endorsement of the outline Annual Plan 2021/22, including the organisational objectives, was received during the development sessions; this enabled a greater focus on the data available that could be drawn on to better inform future decisions and the BAF in respect of risk management.

The revised approach reflects the recommendations of the audits alongside consideration of the comments received as part of the Executive development sessions and comments

received from Internal Audit, Audit Wales and Independent Members of the Audit Committee.

The Revised Approach

The integral premise of the revised approach is based on facilitating the delivery of the Health Boards overarching agreed strategic priorities which are specified in the Health Board's Annual Plan each year. During the course of the development of the Annual Plan the Health Board agreed a revised approach to its planning process and as such, a new set of priorities were agreed. This is integral to the success of the risk management delivery framework as it provides absolute clarity on the strategic objectives.

It is intended that the revised Risk Management approach will form part of the process to deliver the operational objectives to meet the strategic priorities. The delivery plans at operational level will be expected to include threat/risk identification and assessment for each objective; these can then be aggregated and amalgamated to create sets of threats which can then be escalated as strategic risk themes.

Methodology

Appropriate risk management approaches and methods will be required at the various levels of the organisation. It is important to note that the appropriate level of detail required at the differing organisational levels directly impacts on the Health Board's ability to make sound judgements and decisions. At an operational tactical level the appropriate method of determining the threats is not prescriptive as this will be based on the professional service although the previously specified 'bow tie' method can continue to be used alongside 'root cause analysis' for incident management. This will empower operational teams to 'own' their local threats to delivery against their local objectives, whilst ensuring the opportunity to escalate these through the organisation when necessary.

Thematic analysis of the threats will be conducted by the Corporate risk function; the data will then inform the Board Assurance Framework and corporate risk register. It is believed that this will more accurately reflect the actual position of the Health Board in respect of its risks to delivery against its strategic objectives.

In order to provide assurance to the Board and Welsh Government, the appropriate methodology will continue to be the Treasury Three Line Defence Model and will be described within the revised reporting to the Audit Committee, the Board and the BAF:

- ***Internal Control Systems*** – The Health Board's policies, procedures and protocols, many of which are developed and owned locally.
- ***How effective are the controls? -*** This is the area of the risk management approach that will be underpinned by our business intelligence and modelling data. It is proposed that this will become increasingly data rich and will use a scientific analytical approach, providing robust assurance on any key risk. Further focus in respect of the impact mitigating actions will have on residual risks to enable greater clarity on trend analysis will also be developed. It is anticipated that this will provide Board level assurance in an appropriate way i.e. not too much operational detail and with an enhanced focus on the strategic, horizon scanning perspective of risk management.

The Corporate Planning Team has established tracking mechanisms to oversee the implementation of the objectives and priorities incorporating performance data to evidence assurances in areas identified as being a risk to delivery. It is proposed that this evidence is included as part of the risk report to the Executive Team and the Board and forms an aspect of the reporting of the principle risks which will be captured via a dashboard method i.e. incorporating the strategic information related to each risk, on one page ideally. This will become the Health Board's 'risk dashboard' reporting mechanism.

- ***External verification controls are effective*** – This is the way in which the Health Board is held to account by stakeholders and regulatory bodies (HIW, Audit Wales etc.).

The Role of the Executive

Through discussions at the development sessions, it was clear that although Executive Team members accepted that they owned the strategic risks they believed that it was not appropriate for them to inform progress on the risks directly. The assurance on progress often came from respective Divisions therefore, the revised approach would expect the Executive function to become an endorsement of progress against the risks.

It is proposed that development sessions with the Executive Team specifically on risk continue on a bi-monthly basis. These sessions will capitalise on the knowledge, experience and skill of the Executive Team and facilitate horizon scanning for potential future risks. This information would then be taken into consideration when developing and framing the strategic risks to the Health Board.

The Role of Operational Management and Establishment of a Community of Practice

As a key priority over the next 6 months, the Head of Risk and Assurance will seek to identify a core baseline of operational risk managers across the organisation to share examples of best practice, capturing, reporting and escalating risks and to provide support and advice on the approach to risk management. The community of practice will provide a mechanism that evidences the revised approach is embedded amongst the Divisions and Directorates to provide a level of confidence and assurance to the organisation. This mechanism will identify gaps and develop and oversee implementation of action plans in place to ensure a coherent and consistent method is adopted throughout the Health Board.

ICT Application

At the moment there is no digital application that captures risks in a way for them to be monitored and updated regularly. Work is currently being undertaken on a NHS Wales-wide basis to develop a system to record risks on the Once For Wales System (DATIX). This will seek to capture risks reflecting the proposed approach outlined in this report. The application is anticipated to be delivered by April 2022. Updates in relation to this work will be provided to the Executive Team and Audit Committee as and when it becomes available.

Outline Aims/Key Milestones

Task:	By When:	Progress:
Revised and endorsed Risk Management Strategy with appropriate awareness raising ***Establishment of Risk Community of Practice and evidence that revised approach is embedding within the Health Board.***	**September 2021**	Following the revised BAF being presented to the May 2021 Board meeting, development work will commence on revising the Risk Management Strategy. Initial contact being made with Divisions at Quality Patient Safety Operational Group with a view that the Head of Risk and Assurance will attend Divisional QPS meetings to raise profile and identify key risk managers across the organisation.
Performance management data forming an integral part of risk reports to the Audit Committee and the Board. Trend analysis being undertaken and underpinned by an outcomes framework linked to the implementation of the organisational annual plan.	**December 2021**	Discussions are underway with the Assistant Director of Planning to optimise the use of the extension of the Lightfoot contract to develop an outcomes framework to compliment and inform the revised Risk Management approach and framework and to ensure consistent reporting.
National ICT System (DATIX) to be operationalised to mirror the Risk Management arrangements within the Health Board to enable better reporting, escalation arrangements and benchmarking against other Health Boards.	**March 2022**	Health Board attendance at National and Local groups to influence and design the system is currently ongoing.

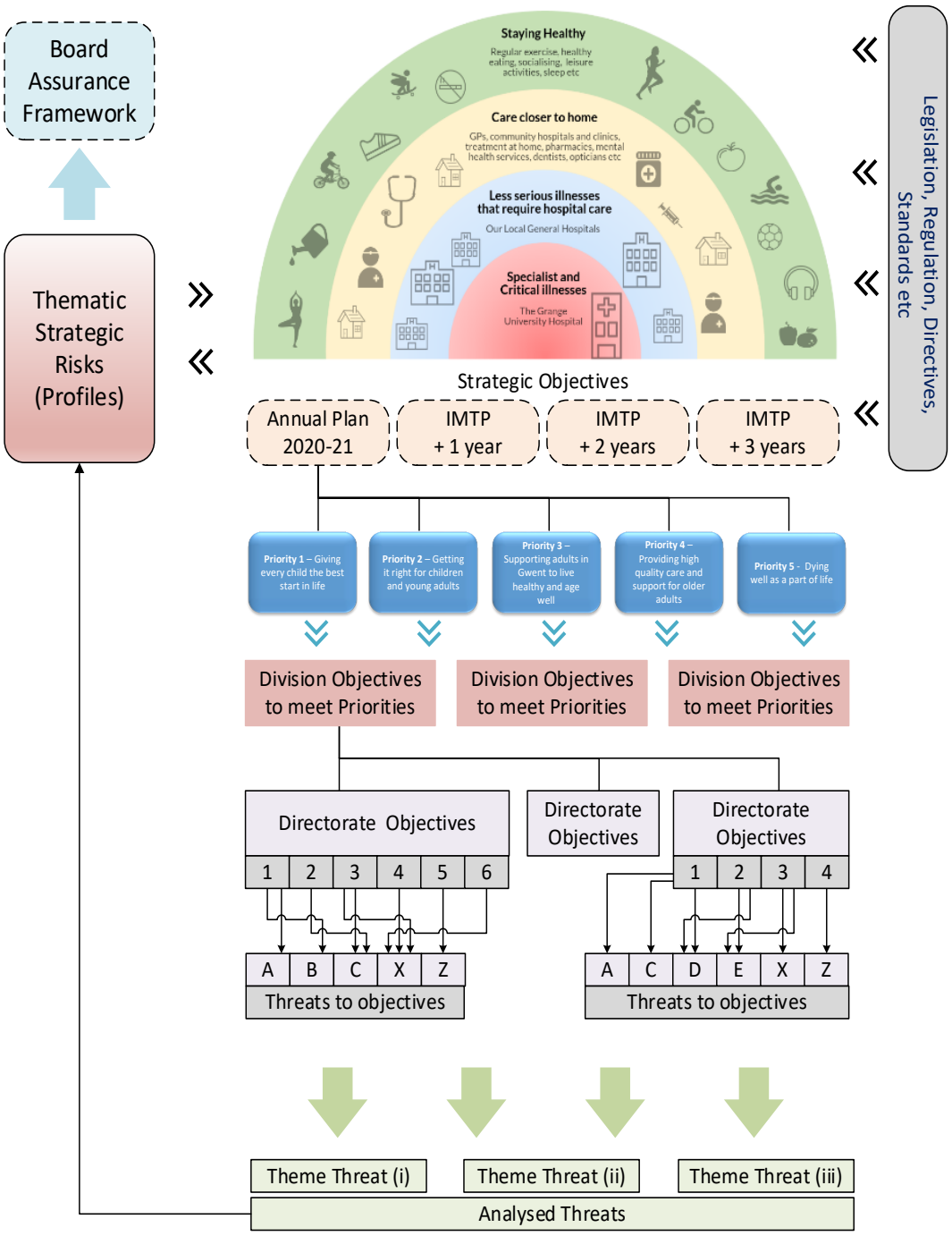
Assessment and Conclusion
It is anticipated that there will be a positive strategic impact of the revised risk management approach as it seeks to further strengthen alignment of key strategies and plans, such as, the Health Board's Clinical Futures Strategy, Fours Harms from COVID, Annual Plan 2021/22, A Healthier Gwent, the Board Assurance Framework and more recently, the Health and Social Care in Wales COVID-19: Looking Forward. It is also anticipated that the approach will also provide a greater level of assurance and clarity to the Board and Welsh Government that the high level, strategic priorities of the Health Board are being risk stratified and directly informed by the themes emerging from risks to delivery against localised objectives within Divisions and Directorates. Mapping has already been undertaken in respect of the Annual Plan 2021/22 priorities, Clinical Futures objectives, the Four Harms from COVID and the some of the Health Board's internal policies, procedures and protocols against the current basket of risks. This will provide an enhanced level of assurance to the Committee and the Board. A performance management approach will then be adopted when assessing the efficacy of these controls and reported as part of the 'objective to a page' mechanism. A diagram depicting the Risk Management Delivery Model is attached at Appendix 1.

Recommendation
Audit Committee is requested to endorse the continued development of the new, strategic corporate risk approach outlined in this report. Subject to formal endorsement from Audit Committee, the proposed timeline in respect of next steps is outlined below: ▶ Board Development Session to receive the revised approach ***28th April 2021*** ▶ Revised BAF presented to the Board ***26th May 2021*** ▶ Revised Risk Management Strategy which incorporates the revised approach, definitions and risk appetite in ***Summer 2021***.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring and reporting of organisational risks are a key element of the Health Boards assurance framework.
Financial Assessment, including Value for Money	This report has no financial consequence although the mitigation of risks or impact of realised risks may do so.
Quality, Safety and Patient Experience Assessment	This report has no QPS consequence although the mitigation of risks or impact of realised risks may do so.

Equality and Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact but the assessments will form part of the objective setting and mitigation processes.
Health and Care Standards	This report contributes to the good governance elements of the H & CS.
Link to Integrated Medium Term Plan/Corporate Objectives	The objectives will be referenced to the IMTP
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to the report, however, considerations will be included in considering the objectives to which the risks are aligned.
Glossary of New Terms	None
Public Interest	Can be published as part of Health Board openness and transparency for Committee papers

Appendix 1


Board Assurance Framework
Thematic Strategic Risks (Profiles)
Staying Healthy
Regular exercise, healthy eating, socialising, leisure activities, sleep etc
Care closer to home
GPs, community hospitals and clinics, treatment at home, pharmacies, mental health services, dentists, opticians etc
Less serious illnesses that require hospital care
Our Local General Hospitals
Specialist and Critical illnesses
The Grange University Hospital
Legislation, Regulation, Directives, Standards etc
Strategic Objectives
Annual Plan 2020-21
IMTP + 1 year
IMTP + 2 years
IMTP + 3 years
Priority 1 – Giving every child the best start in life
Priority 2 – Getting it right for children and young adults
Priority 3 – Supporting adults in Gwent to live healthy and age well
Priority 4 – Providing high quality care and support for older adults
Priority 5 - Dying well as a part of life
Division Objectives to meet Priorities
Division Objectives to meet Priorities
Division Objectives to meet Priorities
Directorate Objectives
1 2 3 4 5 6
A B C X Z
Threats to objectives
Directorate Objectives
Directorate Objectives
1 2 3 4
A C D E X Z
Threats to objectives
Theme Threat (i)
Theme Threat (ii)
Theme Threat (iii)
Analysed Threats

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit, Finance & Risk Committee Thursday, 8th April 2021 Agenda Item: 6.3

Audit, Finance and Risk Committee

Freedom of Information Update for the period 1st April 2020 – 29th February 2021

Executive Summary

The Freedom of Information Act requires reporting on the number of Freedom of Information Requests received and acted upon the Health Board.

The Health Board received a total of 468 requests for the period 1st April 2020 – 29th February 2021 of these 98 were in relation to COVID-19.

The Health Board received no concerns from the Information Commissioners Office (ICO).

The Committee is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			✓
Note the Report for Information Only			
Executive Sponsor: Richard Howells, Interim Board Secretary			
Report Author: Lucy Bennett, Corporate Services Manager (Freedom of Information)			
Report Received consideration and supported by :			
Executive Team	N/A	**Audit, Finance and Risk Committee**	✓
Date of the Report: 31st March 2021			
Supplementary Papers Attached: N/A			

Purpose of the Report

This report provides for the Audit, Finance and Risk Committee an update on the number of Freedom of Information Requests received for the period 1st April 2020 – 29th February 2021.

Background and Context

The Freedom of Information Act aims to ensure transparency and accountability of public organisations. The Act allows anyone to request information or be provided with a copy of documentation about the Health Board and its business; the individual making the request does not have to live locally or provide a reason for the request and the Health Board cannot ask the individual about the reason for their request.

Notwithstanding potential exemptions, the Health Board has to identify if it holds the information requested and provide it within 20 working days.

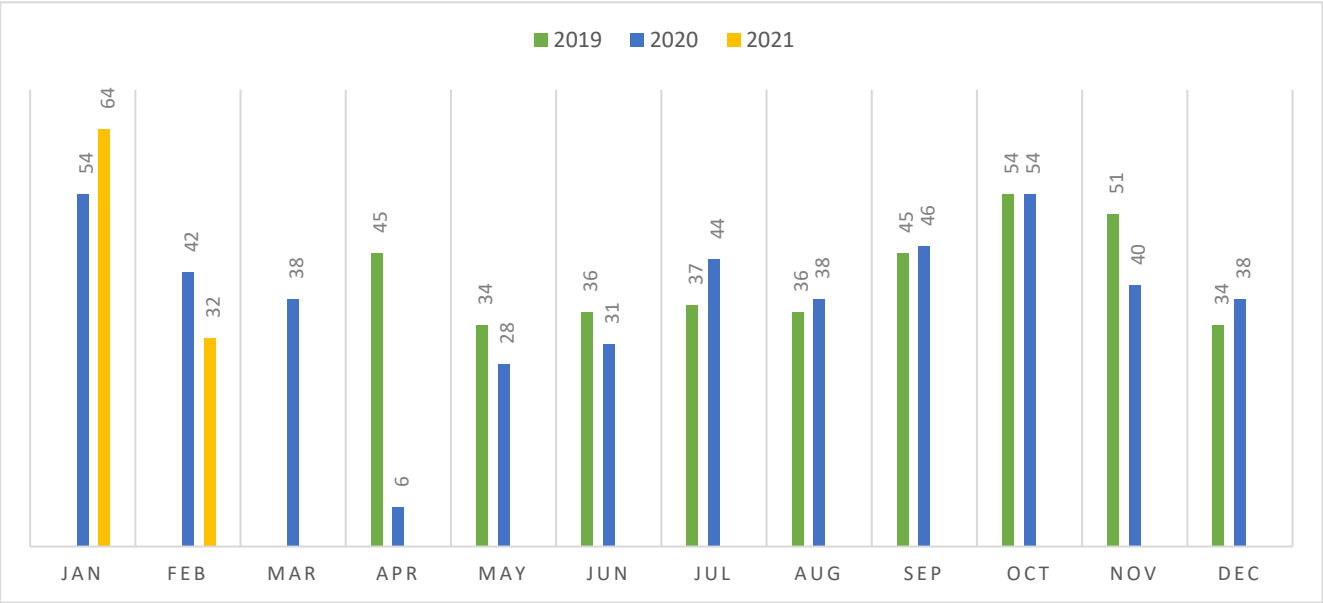
Assessment

1. Freedom of Information requests

For the period 1st April 2020 – 29th February 2021 the Health Board received 468 requests compared to 506 received for the period 1st April 2019 to 31st March 2020.

A total of 98 requests were received in relation to COVID-19 between 1st April 2020 – 29th February 2021.

The graph below provides a month on month comparison of the number of requests received for the period 1st April 2019 to 31st March 2020 and 1st April 2020 to 29th February 2021.



At times requests will be complex, potentially requiring information from multiple sources which means that it is not always possible to provide the information within the 20 day timescale. When it is anticipated that this may happen the Corporate Services Manager (Freedom of Information) liaises with the requester to ensure that they are aware of the possibility of a delay and to agree a revised timescale for response and a formal response is issued notifying the requestor of the potential to respond over the 20 days. This ensures that the Health Board complies with its statutory duties under the Act.

2. Future reports

It is intended to provide future reports on a quarterly basis and these will include detail in relation to themes of requests, compliance rates and any concerns or complaints reported to the Information Commissioners Office.

3. Plans

It is planned to review the Health Board's Publication Scheme to ensure that it provides as much information to the public as possible, in an attempt to reduce the

number of FOIA requests and to ensure that the Health Board remains open and transparent about its business.

Pre-COVID a Freedom of Information Act Stewards Network was created across Divisions which comprised key members of staff to support FOI responses. This will be reviewed to determine the best way forward.

The Wales-wide Community of Practice network also provides invaluable support and advice to ensure that requests received by all Health Boards are responded to in a similar manner.

Recommendation

The Audit, Finance and Risk Committee is asked to note the contents of this report.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The Health Board has a legal responsibility to respond to Freedom of Information requests within 20 working days, as per the Freedom of Information Act 2000.
Financial Assessment, including Value for Money	Not applicable.
Quality, Safety and Patient Experience Assessment	Not applicable.
Equality and Diversity Impact Assessment (including child impact assessment)	Not applicable.
Health and Care Standards	The completion of requests will assist the Health Board's compliance with Health and Care Standard 1 governance.
Link to Integrated Medium Term Plan/ Corporate Objectives	As a legal requirement, this is included in the IMTP.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	As a legal requirement, this ensures compliance with the Act.
Glossary of New Terms	Not applicable.
Public Interest	Freedom of Information data is published and in the public domain.

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

INTERNAL AUDIT PROGRESS REPORT 2020/2021

8 April 2021 Audit Committee

NHS Wales Shared Services Partnership

Audit and Assurance Service

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APPENDIX A – STATUS SCHEDULE
APPENDIX B – KEY PERFORMANCE INDICATORS

1. INTRODUCTION

1.1 The purpose of this report is to highlight progress against the revised 2020/21 Internal Audit Plan at 30th March 2021 to the Audit Committee.

2. PROGRESS AGAINST THE 2020/21 INTERNAL AUDIT PLAN

Number of audits in plan (Phase 1 & 2):	27
Number of audits reported as final	13
Number of audits reported in draft	4
Number of audits in progress	10

2.1 The following reports have been issued since the meeting of the Audit Committee on 4th February 2021:

AUDIT ASSIGNMENT	ASSURANCE RATING
Infection Prevention and Control	Limited
Follow-up on High Priority Recommendations	N/A
Major Capital Project: HSDU	Reasonable
High Voltage Infrastructure	Reasonable
Grange University Hospital - Equipment	Reasonable

2.2 Appendix A details progress in respect of each of the reviews in the 2020/21 Internal Audit Plan.

2.3 Each of the remaining audits listed within the 2020/21 Internal Audit Plan is now in progress or proceeding through the reporting process. We are now proceeding at greater pace, but the timing of delivery remains contingent on the ability of managers to prioritise the provision of the evidence we require.

2.4 As highlighted at February's Audit Committee, reporting of the conclusion of this programme is likely to be later than would be preferable, but we remain optimistic about our ability to complete sufficient internal audit work to enable the provision of the Head of Internal Audit Opinion.

3. SUMMARY OF FINDINGS

3.1 Limited assurance reports are considered by the Audit Committee in detail. The following summary provides the Audit Committee with the main messages from the reasonable assurance and advisory reports issued since the meeting on 4th February 2021.

Follow-up of High Priority Recommendations

3.2 We assessed the implementation of high priority audit recommendations that were scheduled for completion by January 2020. We selected high priority recommendations from 2018/19 and 2019/20 audit reports, in addition to the 2017/18 review of Medical Devices and Equipment.

3.3 We reviewed 20 recommendations in total and found that 12 were partially implemented and one not implemented. We advised the Health Board to review each of these and determine if they should be recorded on the Audit Recommendation Tracker.

3.4 For the recommendations partially implemented we assessed five as more than 50% completed (Charitable Funds, Fire Safety Follow-up, Health and Safety Management, Management of Balance Sheet Assets and the Well-being of Future Generations (Wales) Act 2015).

3.5 The remaining seven partially implemented recommendations were assessed as less than 50% completed (Pay Incentives, Clinical Audit Follow-up and Medical Equipment and Devices). However, we have seen recent planning to address the Clinical Audit and Medical Equipment and Devices recommendations.

Major Capital Project: HSDU

3.6 This audit evaluated the processes and procedures that support the delivery of the Hospital Sterilisation and Disinfection Unit (HSDU) project at the Grange University Hospital (GUH). The capital cost was estimated at £15.77m.

3.7 We found that significant issues arose during the project, which impacted the delivery timeframe (eight week delay) and increased financial cost (within budgeted contingency). We recommended that a lessons learnt exercise is completed, to assist with the delivery of future projects.

3.8 Overall, the contract had appropriate arrangements applied to ensure change management, cost production, valuation assessments and a safe working environment. However, the following issues were identified:

- discrepancies between two (from a sample of 12) of the valuation figures and that reported on the cash-flow report were identified;
- irregular dashboard submissions to the Welsh Government; and
- an absence of a project specific Project Board, with the current process to report into the GUH Project Board.

High Voltage Infrastructure

3.9 We determined the adequacy of the Health Board's procedures and compliance with supporting regulatory and procedural requirements to ensure the safe use of high voltage systems.

3.10 We identified sound operating procedures, including:

- the High Voltage Operational Policy, which is aligned with regulatory requirements;
- trained and appointed Authorised Persons;
- established structures for the governance and management of compliance matters;
- risk assessments, including a reduced electrical supply risk;
- contract management processes; and
- suitable record keeping arrangements in place.

3.11 However, we recommended improvements for the Electrical Safety Group (the 'Group'). For example, the meeting frequency was not in accordance with the terms of reference, there was a lack of clinical representation on the Group and the minutes did not contain sufficient detail for a couple of key points.

3.12 We also recommended that the Group should track actions and recommendations raised within assurance reports.

3.13 We identified missing paperwork for the Limitation of Access forms, where work is undertaken by a maintenance contractor.

Grange University Hospital - Equipment

3.14 This audit sought to ensure that the equipment procured (c.£27.75m) for the opening of the Grange University Hospital (GUH) was progressed in accordance with the Health Board's procedures and national requirements.

3.15 We found that key equipment was procured to meet the deadlines set by the early opening of the GUH in spite of exceptional pressures during the period. Whilst the Health Board was unable to fully test the market because of the urgent timeframe during the pandemic, national and EU procurement regulations were maintained where possible.

3.16 However, we identified the following issues during the audit:

- insufficient engagement from service areas resulted in the equipment schedule not being finalised until nearing project completion. This led to an additional bid submission for £6m and ring-fencing of discretionary capital of £3m;
- since July 2020 there is no dedicated forum to monitor and scrutinise the equipment programme, despite activity continuing after this date;
- we found an insufficient audit trail for 10 of 36 procurement files reviewed; and
- four of the files did not explain where deviations had occurred from the Standing Financial Instructions.

4. 2020/21 INTERNAL AUDIT PLAN UPDATE

4.1 At the request of management we have replaced the phase II scheduled audit of the Q3/4 Delivery Framework with a review of the COVID Implementation Plan, which in turn has been replaced by the audit of Reducing Nosocomial Transmissions.

5. ENGAGEMENT

ADDITIONAL MEETINGS HELD AND COMMITTEES ATTENDED DURING THE REPORTING PERIOD

5.1 Board/Sub Committee/other events:

- Board; and
- Quality & Patient Safety Committee.

5.2 Meetings:

- Regular update meetings regarding the Clinical Futures Programme;
- Audit scoping and debrief meetings;
- Chief Executive quarterly;
- Chair six-monthly;
- Board Secretary regularly;

- Director of Finance and Performance monthly;
- Assistant Director of Finance (Corporate Finance) monthly;
- Audit Committee Chair quarterly;
- Chair bi-annually;
- Planning discussions for the 2021/22 Internal Audit Plan;
- Audit Wales, Health Inspectorate Wales and Ombudsman quarterly;
- Financial process and procedure advice; and
- PADR assurance meeting attendance.

6. 2021/22 INTERNAL AUDIT PLAN

6.1 The 2021/22 Draft Internal Audit Plan has been produced and is reported to the April Audit Committee meeting for approval. The process for the development of the plan is the same as for previous years.

6.2 We are asking for approval of the draft Plan on the basis that it reflects the general risk profile of the organisation as shown in the corporate risk register and rotational coverage of key areas. Due to the ongoing Covid-19 pandemic and the possibility of future surges, it may require revision, both in terms of coverage and timing when it is appropriate to do so. If required, this will be done through the established governance and approval processes.

7. RECOMMENDATION

7.1 The Audit Committee is invited to note the above and approve the proposed change to the Internal Audit Plan and the 2021/22 Draft Internal Audit Plan.

Planned output	Phase	Status	Assurance
Corporate Governance, Risk and Regulatory Compliance			
COVID-19 Governance and Decision Making (Advisory review)	Phase I	Final Report	N/A
COVID Arrangements during COVID-19 Pandemic – Quarter 4 Update	Phase II	Draft Report	
Health and Care Standards	Phase II	Work in Progress	
Strategic Planning, Performance Management and Reporting			
Clinical Futures – Workforce	Phase II	Work in Progress	
Clinical Futures – Transport	Phase II	Work in Progress	
Mass Vaccination Programme	Phase II	Work in Progress	
Financial Governance and Management			
Partnership Financial Governance – Test, Trace and Protect	Phase II	Work in Progress	
BREXIT Preparations	Phase II	Work in Progress	
Clinical Governance, Quality and Safety			
Annual Quality Statement	Phase I	Final Report	N/A
Infection Prevention and Control	Phase I	Final Report	Limited
Safeguarding	Phase I	Final Report	Reasonable

Planned output	Phase	Status	Assurance
Information Governance and Security			
IM&T Control and Risk Assessment	Phase I	Draft Report	
WCCIS	Phase I	Final Report	Substantial
Operational Service and Functional Management			
Mental Health and Learning Disabilities Divisional Review	Phase II	Work in Progress	
Reducing Nosocomial Transmission (formerly Covid Implementation Plan)	Phase II	Work in Progress	
Workforce Management			
Recruitment Checks	Phase I	Final Report	Substantial
Staff Experience	Phase II	Draft Report	
Capital & Estates			
Environmental Sustainability Report	Phase I	Final Report	N/A
Major Capital Project: HSDU	Phase I	Final Report	Reasonable
High Voltage Infrastructure	Phase I	Final Report	Reasonable
The Grange University Hospital Integrated Audit Plan:			
Quality Assurance (Construction Management)	Phase I	Final Report	Substantial
Financial	Phase I	Draft Report	

Planned output	Phase	Status	Assurance
Technical	Phase I	Work in Progress	
Equipment	Phase I	Final Report	Reasonable
Site Management Arrangements	Phase I	Final Report	Substantial
Commissioning and Handover	Phase I	Work in Progress	
Follow-up			
Follow-up on High Priority Recommendations	Phase I	Final Report	N/A

KEY PERFORMANCE INDICATORS

31 March 2021

Indicator	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2020/21	●	April 2020	By 30 April	Not agreed	Draft plan	Final plan
Report turnaround: time from fieldwork completion to draft reporting [10 days]	●	17 of 17	*80%*	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 days]	●	13 of 13	*80%*	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]	●	13 of 13	*80%*	v>20%	10%<v< 20%	v<10%

Audit Assurance Ratings

RATING	INDICATOR	DEFINITION
Substantial assurance	- + Green	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.
Reasonable assurance	- + Yellow	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.
Limited assurance	- + Amber	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.
No assurance	- + Red	The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

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Partneriaeth Cydwasanaethau
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Shared Services Partnership
Audit and Assurance Services

Bwrdd Iechyd Prifysgol Aneurin Bevan
University Health Board

Aneurin Bevan University Health Board

Internal Audit Plan 2021/22

March 2021

NHS Wales Shared Services Partnership
Audit and Assurance Services

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Appendix A Internal Audit Plan 2021/22

Appendix B Key Performance Indicators

Appendix C Internal Audit Charter 2021

1. Introduction

This document sets out the Internal Audit Plan for 2021/22 (the Plan) detailing the audits to be undertaken at Aneurin Bevan University Health Board (the Health Board) and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

As a reminder, the Accountable Officer (the Health Board Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Finance, Audit and Risk Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the findings and recommendations from internal audit reviews may be used by Health Board management to improve governance, risk management, and control within their operational areas.

The Public Sector Internal Audit Standards (the Standards) require that 'The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered in accordance with the internal audit charter and how it links to the organisational objectives and priorities.'

Accordingly, this document sets out the risk-based approach and the Plan for 2021/22. The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Public Sector Internal Audit Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- quantification of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering the:

- organisation's risk assessment and maturity;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning takes into account the NHS Wales Planning Framework and other NHS Wales priorities, and is mindful of significant national

changes that are taking place, in particular the ongoing impact of COVID-19. In addition, the plan aims to reflect the significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and Annual Plan and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Finance, Audit and Risk Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control will require annual review and some others are mandated by Welsh Government, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the audit universe). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we are also aiming to agree a programme of work through both the Board Secretaries and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our audit plan is made up of a number of key components:

1) Annual audit work: Areas where annual audit work will support the most efficient and effective delivery of an annual opinion. These cover the Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management and an overall IM&T assessment. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing where required.

2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the Corporate Risk Register together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.

We recognise that there is a need to audit in a more agile way and to this end we have agreed with some organisations to plan this component of the work on a half-yearly rather than annual basis (the two half year elements making an annual plan). The Health Board has

chosen to have a full annual programme of work identified at this stage recognising that some audits may change during the year.

3) Follow up: this is follow-up work on previous limited and no assurance reports as well as other high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.

4) Work agreed with the Board Secretaries, Directors of Finance, other executive peer groups, or Finance, Audit and Risk Committee Chairs in response to common risks faced by a number of organisations. This may be advisory work in order to identify areas of best practice or shared learning.

5) The impact of audits undertaken at other NHS Wales bodies that impacts on the Health Board, namely PHW, HEIW, NWSSP, Digital Health and Care Wales, WHSSC and EASC.

6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the Final Business Case for major capital bids.

These components are designed to ensure the our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the Health Board's systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; thus, we have considered the following:

- a review of the Board's vision, values and forward priorities as outlined in the Annual Plan and three year Integrated Medium Term Plan (IMTP);
- an assessment of the Health Board's governance and assurance arrangements and the contents of the corporate risk register;
- risks identified in papers to the Board and its Committees (in particular the Finance, Audit and Risk Committee and the Quality and Safety Committee);
- key strategic risks identified within the corporate risk register and assurance processes;
- discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- planned audit coverage of systems and processes provided through NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales, WHSSC and EASC;
- work undertaken by other supporting functions of the Finance, Audit and Risk Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV) where appropriate;
- work undertaken by other review bodies including Audit Wales and Health Inspection Wales (HIW); and
- coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit/Deputy Head of Internal Audit have met with a number of Health Board Executives and Independent Members to discuss current areas of risk and related assurance needs.

Meetings have been held, and planning information shared, with the Health Board Executive Team, the Chair of the Finance, Audit and Risk Committee and the Chair of the Board. The draft Plan was then discussed with the full Executive Team to ensure that internal audit effort was best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework and Corporate Risk Register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also takes into account corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2021/22

The Plan is set out in Appendix A and identifies the audit assignment, lead executive officer, outline scope, and proposed timing. It is structured under the seven components referred to in section 2.2.

Where appropriate the Plan makes cross reference to key strategic risks identified within the corporate risk register and related systems of assurance together with the proposed audit response within the outline scope.

The scope, objectives and audit resource requirements and timing will be refined in each area when developing the audit scope in discussion with the responsible executive director(s) and operational management.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Finance, Audit and Risk Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Finance, Audit and Risk Committee meeting.

Audit coverage, in terms of capital audit and estates assurance, will be delivered by our Capital & Estates Team, and work on Information Governance and IT Security will be delivered by our IM&T Team.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. We are particularly mindful of the level of uncertainty that currently exists with regards to the COVID-19 pandemic. At this stage, it is not clear how the pandemic will affect the delivery of the Plan over the coming year. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the Executive Management Team and endorsed by the Finance, Audit and Risk Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Finance, Audit and Risk Committee for approval.

Regular liaison with Audit Wales as your External Auditor will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

Internal Audit has the necessary resources to deliver the agreed programme through both the local audit team and access to specialist resources.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input necessary to deliver the plan is required during the year over and above the total indicative resource requirement a fee may be charged. Any change to the plan will be based upon consideration of risk and need, and presented to the Finance, Audit and Risk Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Health Board, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

In addition, capital audit work in relation to the Grange University Hospital Project will be charged for separately on the basis of a separately agreed Integrated Audit & Assurance Plan.

6. Action required

The Finance, Audit and Risk Committee is invited to consider the Internal Audit Plan for 2021/22 and:

- approve the Internal Audit Plan for 2021/22;
- approve the Internal Audit Charter; and
- note the associated internal audit resource requirements and key performance indicators.

James Quance
Head of Internal Audit (Aneurin Bevan University Health Board)
Audit & Assurance Services
NHS Wales Shared Services Partnership

Appendix A – Internal Audit Plan 2021/22
Appendix B – Key Performance Indicators
Appendix C – Internal Audit Charter

Planned Output	**Audit Ref**	**Corporate Risk Register**	**Outline Scope**	**Executive Lead**	**Outline timing**
1. Annual Audit Work					
Public Accountability Reporting			To provide commentary on draft public accountability reports, including the Annual Governance Statement.	Chief Executive/ Board Secretary	Q4
Corporate Governance	AB21/22 -01		To review the effectiveness of corporate governance arrangements within the Health Board including the Board Assurance Framework.	Chief Executive/ Board Secretary	Q3
Risk Management	AB21/22 -02		To provide an opinion on the effectiveness of the risk management arrangements in place within the Health Board in order to ensure that strategic objectives are achieved.	Chief Executive/ Board Secretary	Q4
Financial Sustainability	AB21/22 -03	CRR016	To review the key financial management controls within the Health Board including the development and monitoring of savings programmes required for financial sustainability.	Director of Finance and Performance	Q1

Planned Output	**Audit Ref**	**Corporate Risk Register**	**Outline Scope**	**Executive Lead**	**Outline timing**
Quality Framework	AB21/22 -04		To review the effectiveness of the Health Board's quality framework.	Medical Director/Director of Nursing/Director of Therapies and Health Science	Q4
2. Organisation Based Work					
Clinical Futures – Care Closer to Home	AB21/22 -05	CRR009/ CRR012	To assess whether the Health Board is on track to implement its overall objective of care closer to home.	Director of Planning, Digital and IT	Q2
Continuing Healthcare	AB21/22 -06	CRR007	To review the governance arrangements in place to ensure that care is provided to the required standards with appropriate financial controls in operation.	Director of Primary, Community and Mental Health Services	Q3
Flu immunisation	AB21/22 -07	CRR001	To review the arrangements in place for the vaccination of staff and community.	Director of Public Health	Q3
Mental Capacity Act	AB21/22 -08		To assess the extent to which the Health Board complies with the Principles of the Mental Capacity Act, including the DNACPR process.	Director of Nursing	Q1

Planned Output	Audit Ref	Corporate Risk Register	Outline Scope	Executive Lead	Outline timing
Gifts, Hospitality and Declarations of Interest	AB21/22-09		To review the arrangements for registering and managing potential conflicts caused by the receipt of gifts, hospitality and external interests.	Board Secretary	Q1
Clinical Negligence Costs	AB21/22-10		To review the arrangements in place for the management of clinical negligence claims and minimisation of costs associated with them.	Director of Finance and Performance/Medical Director	Q2
Putting Things Right	AB21/22-11	CRR011	To review the arrangements in place for managing the Putting Things Right process and ensure that it remains fit for purpose with the opening of the Grange University Hospital.	Director of Nursing	Q1
Charitable Funds	AB21/22-12		To review key controls in the administration of charitable funds.	Director of Finance and Performance	Q2
Medial Equipment and Devices	AB21/22-13		To assess how the Health Board is managing medical equipment and devices across each site and complying with regulations.	Medical Director	Q3
Medicines Management	AB21/22-14		To review the effectiveness of key controls in respect of medicines management.	Medical Director	Q2

Planned Output	**Audit Ref**	**Corporate Risk Register**	**Outline Scope**	**Executive Lead**	**Outline timing**
Falls Management	AB21/22 -15	CRR010	To assess the implementation of the Falls Prevention Strategy throughout the Health Board.	Director of Nursing	Q2
Controlled Drugs	AB21/22 -16		To assess arrangements in place on wards for the administration and storage of controlled drugs.	Director of Operations	Q4
Monitoring Action Plans	AB21/22 -17		To review the arrangements in place within the Divisions for logging, tracking and implementing recommendations from external reviews.	Director of Nursing	Q3
Datix	AB21/22 -18		To review whether the management and use of the Datix system is proving effective in the identification, escalation and handling of incidents.	Director of Planning, Digital and IT	Q2
NIS Directive	AB21/22 -19	CRR017	To review the implementation of the Directive.	Director of Planning, Digital and IT	Q4
IT System Controls	AB21/22 -20	CRR017	To review the key IT controls in place for a system managed outside of Informatics, ie Cardiology.	Director of Planning, Digital and IT	Q1

Planned Output	**Audit Ref**	**Corporate Risk Register**	**Outline Scope**	**Executive Lead**	**Outline timing**
Operational Plan for Resumption of Services	AB20/21-21	CRR023	To assess the arrangements for resuming services and addressing any backlog of appointments. In particular, how the Welsh Government requirements to re-start services are being adhered to.	Director of Operations	Q1
Flow Centre	AB21/22-22	CRR015	To ensure, sufficient and appropriate staff resources are in place to continually meet the patient requirements within the Flow Centre.	Director of Operations	Q3
Pathology	AB21/22-23	CRR015	To review compliance with key Health Board policies and arrangements to ensure regulatory requirements are met within the department.	Director of Operations	Q1
Facilities Directorate Review	AB21/22-24	CRR015	To review the effectiveness of arrangements in place within Facilities to accommodate an additional hospital site within the Health Board.	Director of Operations	Q2
Catering	AB21/22-25	CRR015	To review the governance and control arrangements in place within the Catering Service.	Director of Operations	Q3

Planned Output	**Audit Ref**	**Corporate Risk Register**	**Outline Scope**	**Executive Lead**	**Outline timing**
Agile Working	AB21/22 -26	CRR002	Advisory review to assess the Health Board's progress in developing agile working practices and identification of good practice.	Director of Workforce & Organisational Development	Q2
Occupational Health	AB21/22 -27	CRR002	To review the effectiveness of Occupational Health services.	Director of Workforce & Organisational Development	Q2
Tredegar Health and Well Being Centre	AB21/22 -28	CRR008	Initial review of project governance arrangements and the management of the construction phase of the project.	Executive Director of Primary, Community and Mental Health Services	TBC
Waste Management	AB21/22 -29		To review the arrangements for disposal of waste within the Health Board.	Director of Operations	Q2
Decarbonisation	AB21/22 -30	CRR004	Review to determine the adequacy of management arrangements to ensure compliance with the Welsh Government decarbonisation strategy.	Director of Operations	Q4

Planned Output	Audit Ref	Corporate Risk Register	Outline Scope	Executive Lead	Outline timing
3. Follow-up					
AB21/22–31 Follow-up will be undertaken towards the end of the financial year.					
4. Work Agreed with Board Secretaries/Directors of Finance/Other Executive Peer Groups					
To be determined.					
5. Audits Undertaken at Other Bodies					
Purchase to Pay		CRR016	Audit undertaken at NWSSP of non-pay expenditure controls.	NWSSP Director of Finance	Q3/Q4
Payroll		CRR016	Audit undertaken at NWSSP of pay expenditure controls.	NWSSP Director of Finance	Q3/Q4
Primary Care Contractor Payments (GMS, GOS, GDS, Pharmacy)		CRR016	Audit undertaken at NWSSP of pay expenditure controls.	NWSSP Director of Finance	Q3/Q4
6. Integrated Audit and Assurance Plans					
Grange University Hospital		CRR015	Integrated Plan separately agreed.	Director of Planning, Digital and IT	Ongoing
Development of Integrated Audit and Assurance Plans			We will work with the Health Board to develop plans for inclusion within the respective business case submissions for other major projects/ programmes (ie Radiotherapy Satellite Centre, Newport East HWBC).		

Planned Output	Audit Ref	Corporate Risk Register	Outline Scope	Executive Lead	Outline timing
Other Activity					
Audit Contingency/follow-up					
Audit planning reporting and management Audit Committee preparation and attendance, Liaison with Audit Wales, Head of Internal Audit Annual Report, follow up of previous audit reports.					

The KPIs reported monthly for Internal Audit are:

KPI	SLA required	Target 2021/22
Audit plan 2021/22 agreed/in draft by 30 April	✓	100%
Audit opinion 2020/21 delivered by 31 May	✓	100%
Audits reported vs. total planned audits	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 days]	✓	80%
Report turnaround management response to draft report [15 days]	✓	80%
Report turnaround draft response to final reporting [10 days]	✓	80%

Aneurin Bevan University Health Board

INTERNAL AUDIT CHARTER

March 2021

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1 Introduction

1.1 This Charter is produced and updated regularly to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:

- Board means the Board of Aneurin Bevan University Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Finance, Audit and Risk Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Aneurin Bevan University Health Board. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Board Secretary.

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measures 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Aneurin Bevan University Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Finance, Audit and Risk Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control[1]. In

[1] *Audit work designed to deliver an audit opinion on the risk management, control, and governance arrangements is referred to in this Internal Audit Charter as Assurance Work because management use the audit opinion to derive assurance about the effectiveness of their controls*

addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
- the appropriate assessment and management of risk, and the related system of assurance;
- the arrangements to monitor performance and secure value for money in the use of resources;
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective advisory service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such advisory work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence as described in the Public Sector Internal Audit Standards is the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Finance, Audit and Risk Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Finance, Audit and Risk Committee on behalf of the Board. Such functional reporting includes the Finance, Audit and Risk Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;

- approving the internal audit budget and resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and
- reporting on internal audit activity's performance relative to its plan.

3.3 Whilst maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.

3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Public Sector Internal Audit Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Finance, Audit and Risk Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the

Public sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Finance, Audit and Risk Committee on behalf of the Board. Accordingly the Head of Internal Audit has a direct right of access to the Accountable Officer the Chair of the Finance, Audit and Risk Committee and the Chair of the organisation if deemed necessary.

4.5 The Finance, Audit and Risk Committee approves all Internal Audit plans and may review any aspect of its work. The Finance, Audit and Risk Committee also has regular private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance e.g. Quality & Patient Safety Committee, and the Information Governance Committee.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Board Secretary will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Board Secretary in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, internal audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

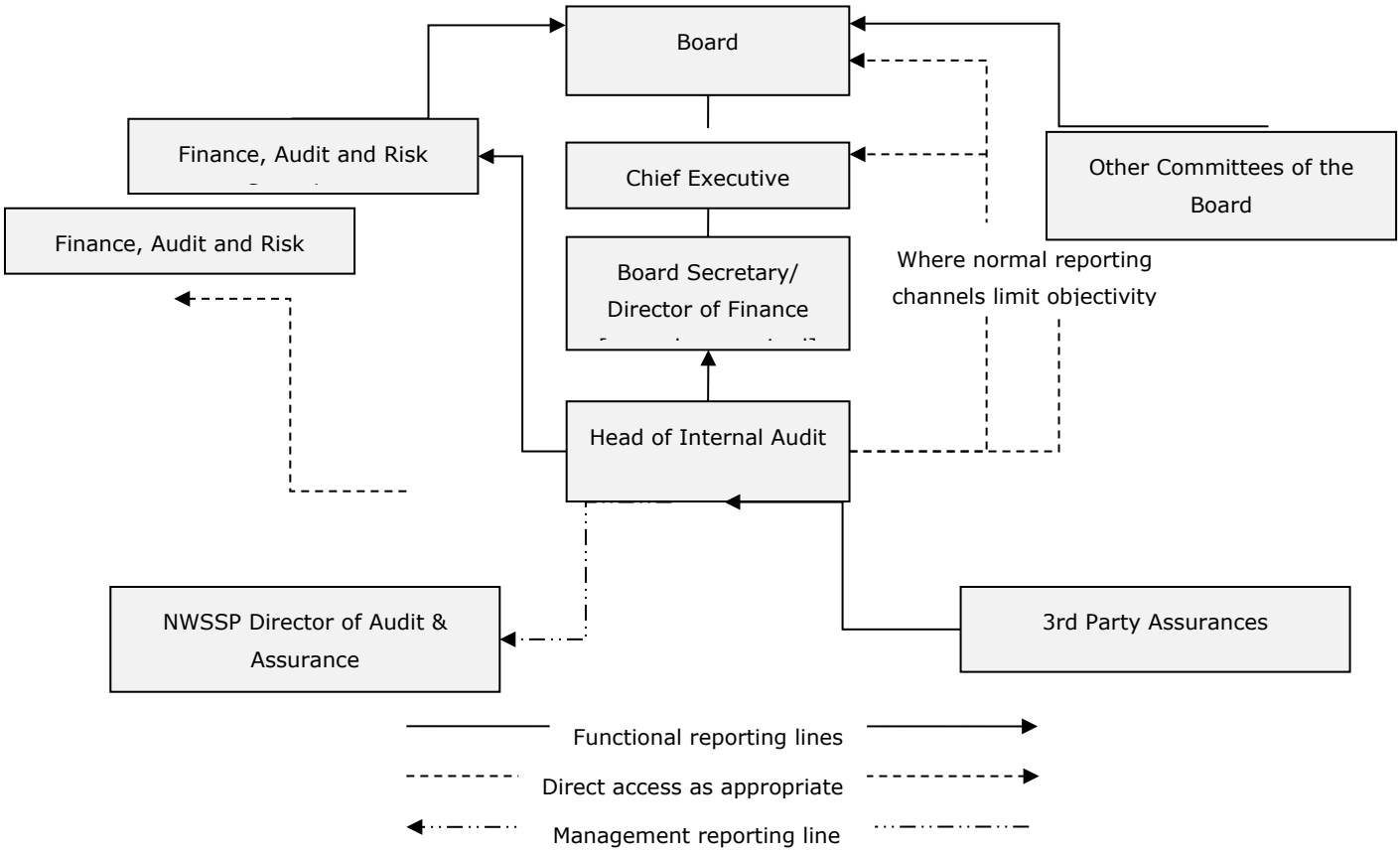
5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, e.g. the NHS Wales Shared Services Partnership, WHSSC, EASC and NWIS.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The key organisational reporting lines for Internal Audit are summarised in Figure 1 overleaf. As part of this, the Finance, Audit and Risk Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Finance, Audit and Risk Committee will remain the final reporting line for all reports.

Figure 1 Audit reporting lines



6 Standards, Ethics and Performance

6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards and the professional Code of Ethics, as published on the NHS Wales e-governance website.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2019) and associated performance standards agreed with the Finance, Audit and Risk Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators and we will agree with each Finance, Audit and Risk Committee which of these they want reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
- reviewing operations or programmes to ascertain whether results are consistent with the organisation’s objectives and goals and whether the operations or programmes are being carried out as planned;
- reviewing specific operations at the request of the Finance, Audit and Risk Committee or management, this may include areas of concern identified in the corporate risk register;

- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;
- reviewing arrangements for demonstrating compliance with the Health and Care Standards;
- ensuring effective co-ordination, as appropriate, with external auditors; and
- reviewing the Governance and Accountability modular assessment and the Annual Governance Statement prepared by senior management.

7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.

7.3 If the Head of Internal Audit or the Finance, Audit and Risk Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit, or prejudice the ability of internal audit to deliver a services consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

7.4 The scope of the audit coverage will take into account and include any hosted body.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 2 overleaf.

Figure 2 Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales to meet
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Public sector Internal Audit Standards and facilitate:

- the provision to the Accountable Officer and the Finance, Audit and Risk Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;

- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which "are appropriate, sufficient and effectively deployed to achieve the approved plan";
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information, and outlining the scope and timing of audit assignments to be completed during the year ahead.

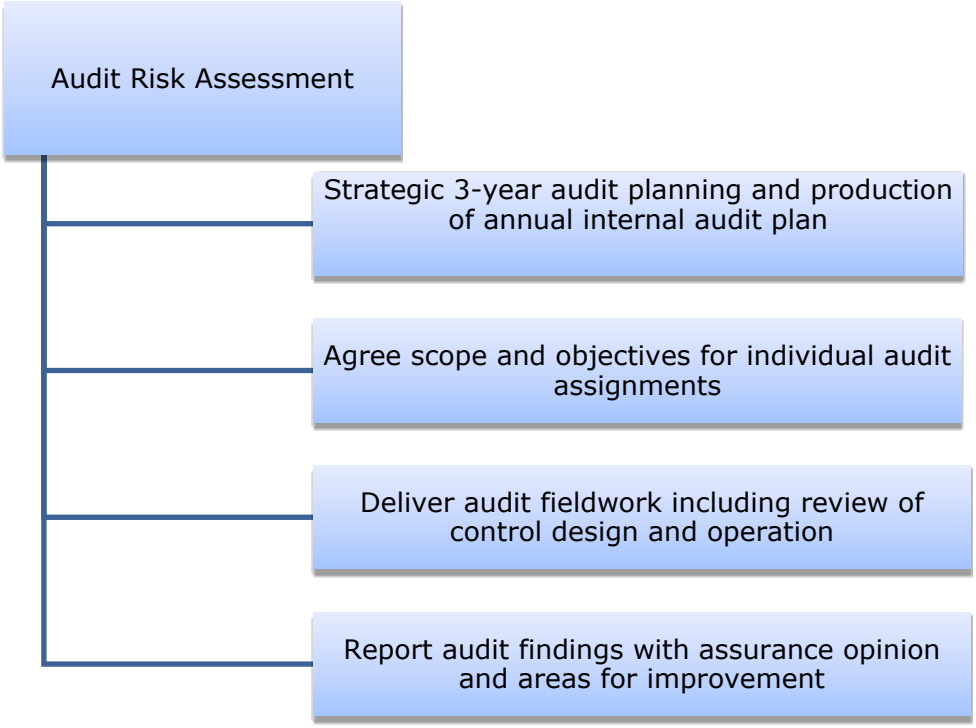
8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Finance, Audit and Risk Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead, and will also be copied to the Board Secretary. The key stages in this risk based audit approach are illustrated in figure 3 below.

Figure 3 Risk based audit approach



9 Reporting

9.1 Internal Audit will report formally to the Finance, Audit and Risk Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement. The process for arriving at the appropriate assurance level for each Head of Internal Audit opinion was subject to a review process during 2013/14, which led to the creation of a set of criteria for forming the judgement that was adopted and used for 2013/14 opinions onwards;

- The Head of Internal Audit opinion will:

a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes, with reference to compliance with the Health and Care Standards;

b) Disclose any qualification to that opinion, together with the reasons for the qualification;

c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;
e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and
f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.

- For each Finance, Audit and Risk Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Finance, Audit and Risk Committee requirements; and

- The Finance, Audit and Risk Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below and presented in flowchart format in Appendix A:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage;
- Operational management will receive draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director;
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B. The draft report will also indicate priority ratings for individual report findings and recommendations;
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, stating their agreement or otherwise to the content of the report, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;

- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate or disagreement remains then the matter will be escalated to the Board Secretary. The Head of Internal Audit may present the draft report to the Finance, Audit and Risk Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Finance, Audit and Risk Committee Chair to ensure that the issues raised in the report are addressed appropriately;
- Reminder correspondence will be issued after the set response date where no management response has been received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Board Secretary. The Head of Internal Audit may present the draft report to the Finance, Audit and Risk Committee where no management response is forthcoming;
- Final reports inclusive of management comments will be issued by Internal Audit to the relevant Executive Director within 10 working days of management responses being received; and
- The final report will be copied to the Accountable Officer and Board Secretary and placed on the agenda for the next available Finance, Audit and Risk Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access shall be granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Public Sector Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to Finance, Audit and Risk Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Finance, Audit and Risk Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition any

matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Director of Shared Services.

14 Review of the Internal Audit Charter

14.1 This Internal Audit Charter shall be reviewed annually and approved by the Board, taking account of advice from the Finance, Audit and Risk Committee.

Simon Cookson
Director of Audit & Assurance - NHS Wales Shared Services Partnership
March 2021

Appendix A Audit Reporting Process

Audit fieldwork completed and debrief with management.	Following closure of audit fieldwork and management review audit findings are shared with management to check accuracy of understanding and shape recommendations for improvement to address any control deficiencies identified.
A draft report is issued within 10 working days of fieldwork completion and the resolution of any queries.	Draft reports issued with an assurance opinion and recommendations within 10 days of fieldwork completion to Operational Management, and copied to Executive Leads.
Management responses are provided on behalf of the Executive Lead within 15 working days of receipt of the draft report.	A report clearance meeting may prove helpful in finalising the report between management and auditors. A response, including a fully populated action plan, with assigned management responsibility and timeframe is required within 15 days of receipt of the Draft report.
Outstanding responses are chased for 5 further days.	Where management responses are still awaited after the 15 day deadline, a reminder will be sent. Continued non-compliance will be escalated to Executive management after 5 further days.
Report finalised by Internal Audit within 10 days of management response.	Internal Audit issues a Final report to Executive Director, within 10 working days of receipt of complete management response. All Final reports are copied to the Chief Executive.
Individual audit reports received by Finance, Audit and Risk Committee.	Final reports are received by the Finance, Audit and Risk Committee at next available meeting and discussed if applicable. For reports with "green/ yellow" assurance ratings, Executive Summaries are received for noting. For those with "red/ amber" ratings, the full reports are received for discussion. The Finance, Audit and Risk Committee identifies their priority areas for Internal Audit to follow up.

Appendix B Audit Assurance Ratings

RATING	INDICATOR	DEFINITION
Substantial assurance	- + Green	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.
Reasonable assurance	- + Yellow	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.
Limited assurance	- + Amber	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.
No assurance	- + Red	The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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Mamhilad Park Estate,
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Contact details

James Quance (Head of Internal Audit) – 01495 300841

Infection Prevention and Control

Final Internal Audit Report
2020/21

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating
Appendix C Responsibility Statement

Review reference:	AB2021-17
Report status:	Draft
Fieldwork commencement:	11th August 2020
Fieldwork completion:	24th September 2020 & 11th March 2021
Draft report issued:	29th September 2020 & 12th March 2021
Management response received:	23rd March 2021
Final report issued:	26th March 2021
Auditor/s:	James Quance, Head of Internal Audit Steve Chaney, Deputy Head of Internal Audit, Rhian Gard, Principal Auditor
Executive sign off	Rhiannon Jones, Executive Director of Nursing
Distribution	Melanie Laidler, Interim General Manager, Primary Care and Community Liz Waters, Assistant Nurse Director Moira Bevan, Lead Infection Control Nurse

Committee

Audit Committee
Quality & Patient Safety Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Please note:

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1. Introduction and Background

The review of Infection Prevention and Control was completed in line with the 2020/21 Internal Audit Plan. The review sought to provide Aneurin Bevan University Health Board (the 'Health Board') with assurance that operational procedures are compliant with Health Board corporate and national policies.

The Health Board's Infection Prevention and Control Policy (the 'Policy') states, 'infection control is 'everyone's business'', 'where one avoidable infection is considered one too many'. With this in mind, the Health Board has a 'zero tolerance' to all preventable infections. This supports the principles of the Health and Care Standards for Wales, Standard 2.4: Infection Prevention Control (IPC) and Decontamination.

As infection prevention and control is an important priority for the Health Board it is committed to the prevention and control of infection as part of service delivery. In order to achieve this, the Health Board has a specialist Infection Prevention and Control (IPAC) Team, which provides an advisory service to all staff on the requirements and procedures for the containment and prevention of infection. However, the IPAC Team needs 'collaboration, full engagement and active support of all Health Board staff from Board to Wards', according to the Policy.

With the recent Covid-19 pandemic outbreak, the IPAC Team has played an active and vital role to contain and prevent the transmission of the virus.

It was noted that during the audit period there was an organisational gap with the absence of a Lead Doctor for IPAC, with the previous post holder leaving the Health Board. To accommodate the extra demand for their services, the IPAC Team moved to a seven day working week.

Looking forward, the IPAC Team are expecting to continue the seven day service whilst also providing advice and support for the infection control agenda in care homes and in some instances the private hospital sector.

2. Scope and Objectives

The overall objective of the internal audit review was to evaluate and determine the adequacy and effectiveness of the internal controls in operation. Any weaknesses have been brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence.

We sought to provide assurance over the following areas:

- the implementation of Covid-19 guidance issued throughout the Health Board, including subsequent revisions and in particular:
    - to ensure the correct guidance was shared with personnel;

    - to confirm that up to date Covid-19 guidance has been acted upon promptly and standard operating procedures (SOPs) updated, as required;
- to assess how the Health Board ensured the following Covid-19 related matters were managed:
    - Covid-19 screening of patients across all Health Board sites;
    - in-patients resident in care home tested prior to returning home (as per national guidance); and
- the management of infection risks was appropriate, notably Clostridium difficile (C. Diff), MRSA.

As part of the audit, we reviewed the key controls in place, including the IPAC Team, to ensure that infection control risks are managed. We also remotely selected a sample of relevant patients throughout the process, to test the operation of the controls in place.

The audit also considered the requirements of Standard 2.4 Infection Prevention and Control (IPC) and Decontamination within the Health and Care Standards (2015), where applicable.

3. Associated Risks

The risks considered in the review were as follows:

- patient harm as a result of avoidable infections;
- incorrect or out-of-date Covid-19 guidance being shared throughout the Health Board;
- Covid-19 guidance issued not being identified, resulting in inappropriate virus management;
- staff not following the correct standard operating procedures;
- patients are not sufficiently screened for Covid-19, resulting in the hospital transmission of the virus;
- insufficient staff to deliver and engage over infection control objectives, resulting in an increased infection rate;
- increased staff sickness, due to inappropriate or non-compliant guidance;
- limited resources available in supporting the Health Board's organisational response to Covid19 resulting in a lack of effective decision making;
- insufficient reporting / escalation to the Board and relevant committees;
- patients are discharged without sufficient testing in place, resulting in an increased community transmission of the virus; and
- other non-Covid infections are not managed sufficiently due to increased resources assigned to Covid related matters.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Infection Prevention and Control is **Limited** Assurance.

RATING	INDICATOR	DEFINITION
Limited Assurance		The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Covid-19 Guidance			✓	
2	Covid19 related matters – screening of patients			✓ **(see note below re: testing limitation)**	
3	Covid-19 related matters – Discharge to care home testing		✓		
4	Management of Health Acquired Infections				✓

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

<u>Testing Limitation</u>

Due to technical restrictions it was not possible to view the evidence of screening results for all patients sampled.

The screening process (which is also consistent with the Pre Admission/ OPD / Diagnostic Covid-19 SOP) requires:

- a patient to provide a temperature reading and answers to a series of symptom questions, prior to entry into a hospital building;
- the patient to be separated into a 'red zone' away from other non-symptomatic / Covid-19 negative patients, where the screening process identifies symptoms of a Covid-19 infection;
- the patient to be tended to within a 'green zone', separate from Covid-19 positive patients, where there are no symptoms of a Covid-19 infection ; and
- the screening results to be manually uploaded onto CWS.

Initially, the process required the results to be uploaded onto specialist software (Symphony). However, we were informed that it is not possible to

operate the software outside of a hospital building, due to a lack of a consistent network signal.

Therefore, the process was amended to manually record the results and upload them into Clinical Work Station (CWS) and for the screening to continue.

We have not been able to fully verify the recording of the results within CWS.

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the system/control design for Infection Prevention and Control.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as a weakness in the operation of the designed system/control for Infection Prevention and Control.

6. Summary of Audit Findings

The Implementation of Covid-19 Guidance

We identified many Covid-19 guidance updates concentrated over a couple of months. These originated from Public Health Wales and the Welsh / UK Government, in addition to professional bodies. The guidance ranged from the use of personal protective equipment (PPE) through to the discharging of patients into different care settings. In total, we identified 19 changes to IPAC SOPs / documentation between March and June 2020. At times, the advice was conflicting between the UK and Welsh Government and professional bodies, with the Health Board determining which advice to adhere to in the best interest of the staff and patients.

Whilst we saw evidence of actions being logged, we were unable to determine if all necessary changes had been implemented at an operational or other applicable level. We examined the Publications Log and found entries detailing key changes in policy and further action required. However, there were frequent gaps within the columns setting out action required, the responsible officer and timeframe. Where these parameters were populated it was not apparent as to whether each action had been completed.

We have raised a recommendation within Appendix A setting out the requirement for tracking and ensuring each recorded action is recorded as implemented on a timely basis.

Covid-19 Screening of Patients

We were informed that all patients presenting to a hospital site are required to undergo screening for the Covid-19 infection prior to entering the building. This is to help identify possible Covid-19 infections and to minimise the transmission risk to other patients.

During the triage process, screening for other conditions (e.g. sepsis) is completed and the results uploaded onto Symphony (the specialist software used). This software was scheduled to be used for the recording of a patient's Covid-19 screening risk result too. However, due to poor network connectivity outside of the hospitals, it was not possible to consistently maintain a connection to the software.

As the risk of transmitting Covid-19 to patients and staff is high, the decision was made to record all results manually and for them to be uploaded onto Clinical Work Station (CWS) retrospectively. However, we were informed that there were difficulties in achieving this process, as screening results were often handed back to patients to pass on to reception personnel, but this was often not completed.

We reviewed CWS to determine if screening evidence had been uploaded for a sample of 20 patients. However, we found eight exceptions where it had not been. Consequently, we are unable to conclude if screening has been completed or whether the results are yet to be uploaded into CWS.

We were informed that a patient would not be able to enter a hospital building without the screening process returning a satisfactory result. However, we have not been able to test this either.

Therefore, whilst the design of the approach taken by the Health Board appears appropriate we are restricted in the assurance that we are able to provide over this objective, as we have not been able to sufficiently test the recording of the results.

In-patients Resident in Care Home Tested prior to Returning Home

We selected a sample of in-patients discharged into a care home to test compliance against the Health Board's SOP, *Gwent Interim Discharge Pathway Covid-19* (approved by the Health Board on 12th June 2020).

The SOP (Section 4.2) sets out that 'The nurse in charge (NiC) will ensure that a patient is swabbed according to the protocol within two days before their medically fit for discharge date (MFD)'.

Within the sample tested (16 in total) we found that:

- seven of the 16 were not tested within 48 hours of their MFD, where:
  - we were informed that one patient was discharged with their Covid-19 result, but we have not been able to confirm this;
  - we were informed that one patient had a fast track swab completed on the day of discharge. However, we have not been able to verify this;
  - four patients were tested within three to four days of their MFD; and
  - one patient was tested within 18 days of their MFD.

The above has been raised as a recommendation within Appendix A.

Management of Infection Risks

The Health Board utilises Datix to record all Health Acquired Infections (HCAIs) and if necessary escalate any issues to the Quality Patient and Safety Committee and / or the Board. The IPAC team also use an internal Excel spreadsheet to record C.diff and MRSA cases and highlight any themes and trends. The IPAC Team also utilise ICNet (a national system), which is a surveillance platform where all HCAI tests are saved and alerts sent to the IPAC Team to action and investigate.

We found the use of the Excel spreadsheet to be a duplication of the details within Datix, with the latter up-to-date, but the internal spreadsheet at times not fully complete. We have not raised this as a separate finding, but rather a point for management to be aware of, without any specific recommendation required.

Utilising data from the Quality and Patient Safety Qlik application, we tested the alignment through to Datix and the corresponding management of infection risks, in particular C.diff and MRSA.

In total, we tested cases of C.diff (10 cases), MRSA (two cases) and pressure ulcers (10 cases) from November 2019 to June 2020. We confirmed that each were reported and managed via Datix. However, we did find one example (C.Diff) where the Datix records were not fully updated (root cause analysis information was absent). This has been raised as a recommendation within Appendix A.

Due to the current pandemic we were unable to test from patient records through to Datix to ensure the complete reporting of incidents, as it is not possible to identify patients linked to incidents outside of Datix.

Finally, we found that there is detailed reporting at an operational level to the divisional quality and patient safety committees, the Reducing Nosocomial Transmission Group and the IPAC Committee. In addition, we confirmed the reporting of infection control performance to the Quality and Patient Safety Committee and the Board, with updates on outbreaks and actions underway.

7. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**1**	**1**	**1**	**3**

Finding 1 Management of Covid-19 Related Matters – Discharge of Patients to Care Home Testing (Operation)	Risk
We selected a sample of patients discharged into a care home to test compliance against the Health Board's SOP, *Gwent Interim Discharge Pathway Covid-19* (approved by the Health Board on 12th June 2020). The SOP (Section 4.2) sets out that 'The nurse in charge (NiC) will ensure that a patient is swabbed according to the protocol within two days before their medically fit for discharge date (MFD)'. This is consistent with the UK Government's *Guidance for the Stepdown of Infection Control Precautions & Discharging Patients (Section 5),* where 'All patients discharged to a care facility should be tested for Covid-19 48 hours prior to discharge and that result should be relayed to the receiving organisation'. Within the sample tested (16 in total) we found that: • seven of the 16 were not tested within 48 hours of their MFD, where: ○ we were informed that one patient was discharged with their Covid-19 result, but we were unable to confirm this; ○ we were informed that one patient had a fast track swab completed on the day of discharge. However, we have not been able to verify this; ○ four patients were tested within three to four days of their MFD; and ○ one patient was tested within 18 days of their MFD.	Increased risk of spreading Covid-19 to vulnerable people and staff within care homes. Increased risk of patient harm from not testing within two days of discharge.

The remaining nine patients sampled were all tested within two days of their MFD.	
Recommendation 1	**Priority level**
The Health Board should: • not discharge an in-patient to a care home setting later than two days after being tested for Covid-19, with discharge refused until a negative test result is returned; • issue a communication through Divisional / Senior nurses of the SOP that is in place and offer training / clarification where required; • ensure that the date of the Covid-19 test is fully visible on CWS and a key component of the discharge process; and • ensure real-time monitoring takes place to prevent patients being discharged as an in-patient without an up-to-date negative Covid-19 test result.	**High**

Management Response 1	Responsible Officer/ Deadline
The health board acknowledges the importance of timely swabbing not only in line with medically fit dates but through timely and effective communication as to when a care home can safely accept the patient back into their care. A number of key measures are now in place to support the discharge process: • Daily closed settings information shared between significant Local Authority members and ABUHB staff regards Care homes with concerns with Covid cases and outbreaks to ensure patients are not discharged to vulnerable areas; • All patients are now discharged back to care homes with completed 'discharge passport' documentation so that we are not only applying appropriate Covid consideration for patients but those vulnerable people they also reside with; The audit did not provide assurance regarding compliance with discharge procedures but the discharge passport, as referenced above, has been implemented to ensure all patients have a negative test result or low infectivity risk prior to discharge. The Welsh Government guidance on inpatient testing now recommends testing all patients upon admission to hospital and again after 5 days. Results will be viewable on CWS like any pathology test. The expected turnaround time from sample to collection to result is 24-48 hours.	No further action required

Finding 2 Covid-19 Guidance (Design)	Risk
The Health Board maintains a Publication Log detailing all relevant Covid communication received. Alongside each publication / communication there may be further action required, with a responsible owner and timeframe for completion. However, from the 400 entries within the Log, 83 required further action, but 8 of the 83 had no timeframe set for completion. For each of the 83 cases, there was no information confirming if each had been fully implemented or not. Furthermore, 17 entries required cascading / guidance / dissemination, but three had no details of action or deadline required. As above, there were no details confirming if the actions had been fully completed.	Actions relating to guidance changes are not monitored for completion.
Recommendation 2	**Priority level**
The Health Board should ensure: • the responsible owner confirms that all appropriate actions have been implemented; and • the Publication Log should be fully completed, to enable sufficient tracking of outstanding actions.	**Medium**

Management Response 2	Responsible Officer/ Deadline
During the response period there was a robust approach to tracking actions in place; managed through the Gold/Executive Team action log. An update on outstanding actions is scheduled for Executive Team regularly. It is deemed no further action is required on this as the Action Log tracker provides the evidence of actions as opposed to the Publication Log.	No further action required.

Finding 3 Recording of Root Cause Analysis on Datix (Operation)	Risk
We tested the completion of Datix for the management of infections risks, in particular C.diff and MRSA. In total, we tested cases of C.diff (10 cases), MRSA (two cases) and pressure ulcers (10 cases) from November 2019 to June 2020. We confirmed that each were reported and managed via Datix, with the exception of one example (C.Diff) where the Datix records were not fully updated, with the root cause analysis information being absent. However, we found evidence of the Executive Team oversight and management of the C.Diff outbreaks, with trend and root cause analysis reported. Utilising this information actions were implemented to reduce the risk of reoccurrence (e.g. hand hygiene audits, communiques issued, focus on bundle compliance and organisation wide messaging on the prudent use of antibiotics prescribing).	Insufficient learning obtained from C.Diff outbreaks.
Recommendation 3	**Priority level**
The Health Board should: • ensure that the root cause analysis for all C.Diff infection outbreaks is entered into Datix.	**Low**

Management Response 3	Responsible Officer/ Deadline
In ordinary times RCA's are diligently completed and uploaded onto Datix. We know that RCA's were difficult & challenging to undertake at the height of the pandemic in surge 1 (& 2) due to the intensity of workload for the IPAC team, as well as deficits in the team, as a direct result of the pandemic. It is not unreasonable to find one case out of the sample that had not been completed in the circumstances. This finding has, however, been shared with the IPAC Team and the one case is being reviewed and results will be uploaded on Datix.	No further action required.

Audit Assurance Ratings

Substantial assurance - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

Reasonable assurance - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

Limited assurance - The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

No Assurance - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

*Unless a more appropriate timescale is identified/agreed at the assignment.

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

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Audit Wales

Finance, Audit and Risk Committee Update – Aneurin Bevan University Health Board

Date issued: March 18, 2021

Document reference: 2059A2020-21

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Finance, Audit and Risk Committee Update

About this document

1 This document provides the Finance, Audit and Risk Committee with an update on current and planned Audit Wales work. Accounts and performance audit work are considered, and information is also provided on the Auditor General's wider programme of national value-for-money examinations and the work of our Good Practice Exchange (GPX).

Accounts audit update

2 **Exhibit 1** summarises the status of our key accounts audit work to be reported during 2021-22.

Exhibit 1 – Accounts audit work

Area of work	Current status
2021 Audit Plan	On the agenda.
Audit of Accounts Report	June 2021
Charitable Funds: • 2021 Audit Plan • Audit of Charitable Funds financial statements	Autumn 2021 To be presented to the Charitable Funds Committee – Date to be confirmed
2021 Annual Audit Report	Not yet started.

3 Our financial statements planning, and interim audit work is progressing well, and there are no significant matters that we wish to draw to the Committee's attention at this time.

Performance audit update

4 The following tables set out the performance audit work included in our current and previous Audit Plans, summarising:

- work completed (**Exhibit 2**);
- work that is currently underway (**Exhibit 3**); and
- planned work not yet started or revised (**Exhibit 4**)

Exhibit 2 – Work completed

Area of work	Considered by Audit Committee
Test, Track and Protect	Completed and national report published 18th March (see Exhibit 5 for a weblink to the report).

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Finance, Audit and Risk Committee consideration
Orthopaedic: Follow up review Executive lead: Claire Birchall	This review examined the progress made in response to our 2015 recommendations. The findings from this work will inform the recovery planning discussions that are starting to take place locally and help identify where there are opportunities to do things differently as the service looks to tackle the significant elective backlog challenges. Our findings will be summarised into a single national report with supplementary outputs setting out the local position for each health board.	Report drafting - publication of the national report delayed until May. Date for consideration to be confirmed.

Topic and relevant Executive Lead	Focus of the work	Current status and Finance, Audit and Risk Committee consideration
Welsh Health Specialised Services Committee (WHSSC) Executive lead: Judith Paget	This work is being undertaken nationally and uses aspects of the Structured Assessment methodology to examine the governance arrangements of WHSSC work. Our findings will be summarised into a single national report.	Report in clearance; publication expected early May. Date for consideration to be confirmed.
Review of arrangements for securing efficiencies Executive lead: Glyn Jones	This work will consider whether the Health Board's arrangements for securing efficiencies are robust, including the impact of new ways of working on planned efficiencies.	Reporting delayed; clearance expected to start in April. Planned date for consideration - August 2021.
Quality Governance Executive leads: Rhiannon Jones and Peter Carr	This work will examine both the operational and corporate approach to quality governance, looking at issues such as organisational culture and behaviours, strategy, structures and processes, information flows and reporting.	Timetable for evidence gathering extended to September given ongoing COVID pressures. Planned date for consideration - December 2021.
Radiology services follow-up Executive lead: Claire Birchall	This work will examine the progress made by the Health Board to address our 2017 recommendations and identified areas for improvement in the context of the opening of the Grange University Hospital.	Set-up meeting held and evidence gathering underway. Planned date for consideration - August 2021.

Topic and relevant Executive Lead	Focus of the work	Current status and Finance, Audit and Risk Committee consideration
Structured Assessment 2021	Structured assessment continues to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. The work is in two phases. Phase 1 - examines the effectiveness of operational planning arrangements when NHS bodies continue to respond to the pandemic and to recover and restart services. Phase 2- examines how well NHS bodies are embedding sound arrangements for corporate governance and financial management, as well as drawing on lessons learnt from the initial response to the pandemic.	Phase 1 – evidence gathering underway. Phase 2 – scheduled to start in May. Planned date for consideration - August 2021.

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Finance, Audit and Risk Committee consideration
Unscheduled care arrangements Executive lead: tbc	The work examines different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. This will be followed by more detailed work focusing on the	Data analysis currently being completed with a national commentary due for publication in June. Further work not yet started.

Topic and relevant Executive Lead	Focus of the work	Current status and Finance, Audit and Risk Committee consideration
	mechanisms for managing demand for unscheduled care and patient flow through the system. [This work was part of the 2020 audit plan but paused during the early stages of the pandemic and replaced with work on Test, Track and Protect. This work is resuming as part of the 2021 audit plan.]	Date for consideration to be confirmed
Locally focused audit project	The precise focus of this work is still to be agreed.	Date for consideration to be confirmed

Good Practice events and products

5 In addition to the audit work set out above, we continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design and good practice research.

6 In response to the Covid-19 pandemic, we established a **Covid-19 Learning Project** to support public sector efforts by sharing learning through the pandemic. This is not an audit project; it is intended to help prompt some thinking, and hopefully support the exchange of practice. We have produced a number of outputs as part of the project that are relevant to the NHS, as well as holding a week long learning event the details of which are available here.

NHS-related national studies and related products

7 The Finance, Audit and Risk Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee at the Senedd to support its scrutiny of public expenditure.

8 We have published one NHS-related report since the Committee last met in February. **Exhibit 5** provides information on this report.

Exhibit 5 – NHS-related or relevant national studies reports

Title	Publication Date
Test, Trace, Protect in Wales: An Overview of Progress to Date	March 2021

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

2021 Audit Plan – **Aneurin Bevan University Health Board**

Audit year: 2021

Date issued: March 2021

Document reference: 2248A2021-22

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

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2021 Audit Plan

About this document

1 This document sets out the work I plan to undertake during 2021 to discharge my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice.

Impact of COVID-19

2 The COVID-19 pandemic continues to have an unprecedented impact on the United Kingdom and the work of public sector organisations.

3 Audit Wales staff will continue to work pragmatically to deliver the audit work set out in this plan. In response to the government advice and subsequent restrictions, we will continue to work remotely until such time that it is safe to resume on-site activities. I remain committed to ensuring that the work of Audit Wales staff will not impede the vital activities that public bodies need to do to respond to on-going challenges presented by the COVID-19 pandemic.

4 This audit plan sets out an initial timetable for the completion of my audit work. However, given the on-going uncertainties around the impact of COVID-19 on the sector, some timings may need to be revisited.

Audit of financial statements

5 I am required to issue a report on the Aneurin Bevan University Health Board's (the Health Board) financial statements which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure. In preparing such a report, I will:

- give an opinion on your financial statements;
- give an opinion on the proper preparation of key elements of your Remuneration and Staff Report; and
- assess whether your Annual Governance Statement and other information presented with the financial statements are prepared in line with guidance and consistent with the financial statements.

6 I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities, along with further information about our work.

7 I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material will be reported to the Audit Committee prior to completion of the audit.

8 Any misstatements below a trivial level (set at 5% of materiality) I judge as not requiring consideration by those charged with governance and therefore will not report them.

9 I will also report on your charitable funds' accounts. I will issue a separate Audit Plan for the audit of the Charitable Funds accounts.

10 There have been no limitations imposed on me in planning the scope of this audit.

Audit of financial statement risks

11 The following table sets out the significant risks that have been identified for the audit of your financial statements.

Exhibit 1: audit of financial statement risks

Financial audit risks	Proposed audit response
Significant risks	
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	The audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; and • evaluate the rationale for any significant transactions outside the normal course of business;
There is a significant risk that you will fail to meet your first financial duty to break even over a three- year period. Following a core 'Financial Stability' funding allocation for COVID-19 from Welsh Government of £70m and further COVID-19 allocations of £52m, coupled with the avoidance of certain costs due to COVID-19, the position at month 11 shows a year-to-date surplus of £0.176 million and a forecast break-even year-end position. This combined with the outturns for 2018-19 and 2019-20,	The audit team will focus its testing on areas of the financial statements which could contain reporting bias.

Financial audit risks	Proposed audit response
predicts a three-year surplus of £0.267 million. Where you were to fail this financial duty, we will place a substantive report on the financial statements highlighting the failure and qualify your regularity opinion. Your current financial pressures increase the risk that management judgements and estimates could be biased in an effort to achieve the financial duty.	
The COVID-19 national emergency continues and the pressures on staff resource and of remote working may impact on the preparation and audit of accounts. There is a risk that the quality of the accounts and supporting working papers may be compromised leading to an increased incidence of errors. Quality monitoring arrangements may be compromised due to timing issues and/or resource availability.	We will discuss your closedown process and quality monitoring arrangements with the accounts preparation team and monitor the accounts preparation process. We will help to identify areas where there may be gaps in arrangements.
The increased funding streams and expenditure in 2020-21 to deal with the COVID-19 pandemic will have a significant impact on the risks of material misstatement and the shape and approach to our audit. Examples of issues include accounting for the early opening of the Grange University Hospital; regularity risks of additional spend; valuation of year-end inventory including PPE; and estimation of annual leave balances.	We will identify the key issues and associated risks and plan our work to obtain the assurance needed for our audit.
Where year-end stock balances are material to the financial statements, ISA501 – *Audit Evidence – Specific considerations for selected items*, requires auditors to attend the physical year-end stock count. Due to Audit	We will maintain ongoing discussions with the finance team to monitor the forecast year- end stock balances and plan our work to obtain the assurance needed for our audit. Where the year-end stock balance is

Financial audit risks	Proposed audit response
Wales' policy in response to the pandemic, audit staff are unable to work at client sites and therefore are unable to attend physical stock takes. As a result, where year-end stock balances are material and auditors are unable to attend the physical year-end stock count, the auditor shall modify the opinion in the auditor's report in accordance with ISA701– *Communicating key matters in the independent auditor's report.*	material and we are unable to comply with the requirements of ISA501, we will determine the impact on the audit report and discuss our proposed modified audit opinion with officers/management.
A phased deployment of the new WellSky Hospital Pharmacy System was commenced by NWIS from November 2020 across Welsh health bodies and is planned to be completed in July 2021 (COVID pandemic disruptions allowing). The Wellsky system was implemented in the Aneurin Bevan UHB in November 2020. The financial expenditure balances for hospital drugs, medicines and other pharmaceutical items flowing through the Wellsky system will be material to the Health Board. The data transfer from the old hospital pharmacy system to Wellsky was completed manually by the Health Board before the system went live on 9 November 2020, and responsibility for the design and implementation of effective controls over the transfer process rested with the Health Board.	We will review the process for transferring the data to the Wellsky system and the controls in place, to ensure the opening balances are an accurate starting point to continue calculating the financial throughput of expenditure in the new WellSky system.
The implementation of the 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff is ongoing. Last year we included an Emphasis of matter paragraph in the audit opinion drawing attention to your disclosure of the contingent liability. However, if any expenditure is made in year, we would consider it to be irregular	We will review the evidence one year on around the take up of the scheme and the need for a provision, and the consequential impact on the regularity opinion.

Financial audit risks	Proposed audit response
as it contravenes the requirements of Managing Public Monies.	
Due to the COVID 19 pandemic and in light of the Coronavirus Act 2020, health bodies across Wales are required to accrue for untaken annual leave as at 31 March 2021. The All Wales Technical Accounting Group has met to agree a common methodology to be applied, and the calculations based on this for each health body will be submitted to Welsh Government. It is anticipated that the annual leave accrual will be funded although this has not been confirmed. The accrued annual leave balance will be material to the Health Board's accounts for 2020-21 and as at 31 January 2021, the Health Board has estimated the accrual to be £20.3million.	The audit team will: • assess the appropriateness of the proposed methodology for calculating the accrual • test to ensure the estimate has been calculated in line with agreed methodology
Other areas of audit attention	
Introduction of IFRS 16 Leases has been deferred until 1 April 2022 and may pose implementation risks. There is considerable work required to identify leases and the COVID-19 national emergency may pose implementation risks.	The audit team will undertake some early work to review preparedness for the introduction of IFRS 16 Leases. See **Appendix 2 Exhibit 7** for more detail.

Performance audit work

12 In addition to my Audit of Financial Statements, I must also satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

13 Where appropriate, I will also take opportunities to assess the extent to which the Health Board is acting in accordance with the sustainable development principle[1] as per my duties set out in the Well-being of Future Generations (Wales) Act 2015. This work will be informed by the responses to my recent consultation on how I approach my duties in respect of the Act. I will be writing to the public bodies designated in the Act setting out the results of the consultation and how I intend to approach this work over the reporting period 2020-25.

14 My work programme is informed by specific issues and risks facing the Health Board and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit. Exhibit 2 sets out my current plans for performance audit work in 2021.

Exhibit 2: My planned 2021 performance audit work at the Health Board

Theme	Approach/key areas of focus
NHS Structured Assessment	Structured assessment will continue to form the basis of the work auditors do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. The plans for 2021 structured assessment work reflect the ongoing arrangements of NHS bodies in response to the COVID-19 emergency. My 2021 work will be undertaken in two phases. Phase 1 will review the effectiveness of operational planning arrangements to help NHS bodies continue to respond to the challenges of the pandemic and to recover and restart services. Building on last year's work, Phase 2 will examine how well NHS bodies are embedding sound arrangements for corporate governance and financial management, drawing on lessons learnt from the initial response to the pandemic.
All Wales Thematic Reviews	**Unscheduled care arrangements** My 2020 audit plans included a thematic review examining different aspects of the unscheduled care system. However, this work was paused during the early stages of the pandemic and then ultimately replaced to

[1] The Act defines the sustainable development (SD) principle as acting in a manner: '…which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs'

Theme	Approach/key areas of focus
	allow resources to be diverted to a high-level review of the Test, Trace and Protect (TTP) programme. My planned work on unscheduled care will now be delivered as part of my 2021 programme. It will include an analysis of national data sets, a high-level commentary of the performance of the unscheduled care system. This will be followed by more detailed work focusing on the mechanisms for managing demand for unscheduled care and patient flow through the system. **COVID-19 related outputs** I also plan to use an element of the 2021 audit fee to respond to aspects of the pandemic where my insight and knowledge across Wales will provide value to NHS bodies. The precise focus of this work will be kept under review and will be reflected in the regular updates that are produced for the Audit Committee.
Locally focused work	Where appropriate, I will also undertake thematic performance audit work that reflects issues specific to the Health Board. The precise focus of this work will be agreed with executive officers and the Audit Committee and will be reflected in the regular updates that are produced for the Audit Committee.
Implementing previous audit recommendations	My structured assessment work will include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having. Expectations on the implementation of previous audit recommendations will be adjusted as appropriate to take account of the impact on COVID-19.

15 The performance audit projects included in last year's audit plan, which are either still underway or which have been substituted for alternative projects in agreement with you, are set out in **Appendix 1**.

Fee, audit team and timetable

16 My fees and the planned timescales for completion of the audit are based on the following assumptions:

- the financial statements are provided to the agreed timescales, to the quality expected and have been subject to quality assurance review;
- information provided to support the financial statements is in accordance with the agreed audit deliverables within the Health Board's internal timetable 2020-21[2];
- appropriate facilities and access to documents are provided to enable my team to deliver our audit in an efficient manner;
- all appropriate officials will be available during the audit;
- you have all the necessary controls and checks in place to enable the Accounting Officer to provide all the assurances that I require in the Letter of Representation addressed to me; and
- Internal Audit's planned programme of work is complete, and management has responded to issues that may have affected the financial statements.

Fee

17 Fee rates for 2021 are unchanged from last year. The estimated fee for 2021 is set out in Exhibit 3. This represents no change in the estimated fee compared with your actual 2020 fee.

Exhibit 3: audit fee

Audit area	Estimated fee for 2021 (£)[3]	Actual fee for 2020 (£)
Audit of Financial Statements:	220,154	220,154
Performance audit work:		
• Structured Assessment	64,237	59,761
• All-Wales thematic reviews[4]	68,807	69,168
• Local projects	19,948	24,063
Performance work total	152,992	152,992
Total fee	373,146	373,146

[2] The agreed audit deliverables are the expected working paper requirements to support the financial statements and include timescales and responsibilities.

[3] The fees shown in this document are exclusive of VAT, which is not charged to you.

[4] As detailed in the respective audit plans.

18 Planning will be ongoing, and changes to our programme of audit work and therefore the fee, may be required if any key new risks emerge. We shall make no changes without first discussing them with the Director of Finance.

19 Further information on my fee scales and fee setting can be found on our website.

Audit team

20 The main members of the audit team, together with their contact details, are summarised in Exhibit 4.

Exhibit 4: my local audit team

Name	Role	Contact number	E-mail address
Richard Harries	Audit Director (Financial Audit), and Audit Wales Engagement Director for the Health Board	07789 397018	Richard.Harries@audit.wales
Dave Thomas	Audit Director (Performance Audit)	029 20320604	Dave.Thomas@audit.wales
Tracy Veale	Audit Manager (Financial Audit)	07919 217438	Tracy.Veale@audit.wales
Neall Hollis	Audit Lead (Financial Audit)	029 20320657	Neall.Hollis@audit.wales
Gabrielle Smith	Audit Lead (Performance Audit)	029 20320608	Gabrielle.Smith@audit.wales

21 I can confirm that my team members are all independent of the Health Board and its officers. There is one potential conflict of interest that I need to bring to your attention. Gabrielle Smith's husband is Clinical Director of the University Dental Hospital, Cardiff and Vale University Health Board. The University Dental Hospital

is contracted to provide services to the Health Board for restorative dentistry and advanced oral oncology. Our Law and Ethics team has undertaken a detailed review and concluded that the possibility of this relationship affecting the audit work that Gabrielle undertakes to be remote. However, we have taken steps to ensure that Gabrielle is not involved in any work we may do at the Health Board that examines the contracts for restorative dentistry and advanced oral oncology.

Timetable

22 The key milestones for the work set out in this plan are shown in Exhibit 5. As highlighted earlier, there may be a need to revise the timetable in light of developments with COVID-19.

Exhibit 5: Audit timetable

Planned output	Work undertaken	Report finalised
2021 Audit Plan	January 2021	February to March 2021
Audit of Financial statements work: • Audit of Financial Statements Report • Opinion on Financial Statements • Financial Accounts Memorandum (if required)	January to June 2021	June 2021 June 2021 July 2021
Performance audit work: Structured Assessment Unscheduled Care COVID-19 outputs Local project work	Timescales for individual projects will be discussed with you and detailed within the specific project briefings produced for each study.	
2022 Audit Plan	December 2021 to January 2022	February to March 2022

Appendix 1

Performance audit work in last year's audit plan still in progress

The following table summarises the status of the audit work in last year's audit plan which is still in progress.

Exhibit 6: Performance audit work still in progress.

Performance audit project	Status	Comment
Review of Welsh Health Specialised Services Committee	Reporting	A national report is due to be published in May 2021.
Unscheduled Care	Fieldwork	This work was paused as a result of the pandemic and replaced with a review of the Test, Trace and Protect (TTP) programme. Unscheduled care work has been carried forward to feature in this year's plan.
Radiology Services Follow-up of Recommendations	Project Brief issued	Fieldwork is underway and expected to conclude in May.

Appendix 2

Other future developments

Forthcoming key IFRS changes

This table details the key future changes to International Financial Reporting Standards

Exhibit 7: changes to IFRS standards

Standard	Effective date	Further details
IFRS 16 Leases	1 April 2022	IFRS 16 will replace the current leases standard IAS 17. The key change is that it largely removes the distinction between operating and finance leases for lessees by introducing a single lessee accounting model that requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. It will lead to all leases being recognised on balance sheet as an asset based on a 'right of use' principle with a corresponding liability for future rentals. This is a significant change in lessee accounting.
IFRS 17 Insurance Contracts	2023-24 at earliest	IFRS 17 replaces IFRS 4 *Insurance Contacts*, which permitted a variety of accounting practices resulting in accounting diversity and a lack of transparency about the generation and recognition of profits. IFRS 17 addresses such issues by requiring a current measurement model, using updated information on obligations and risks, and requiring service results to be presented separately from finance income or expense. It applies to all insurance contracts issued, irrespective of the type of entity issuing the contracts, so not relevant only for insurance companies. Entities will need to consider carefully whether any contractual obligations entered into meet the definition of an insurance contract. If that is the case, entities will need to determine whether they are covered by any of IFRS 17's specific scope exclusions.

Future changes to UK GAAP: applicable to charitable funds accounts

Following the introduction of the new UK GAAP accounting regime in 2015-16, and the replacement of the Financial Reporting Standard for Smaller Entities (FRSSE) by Section 1A of FRS 102 in 2016-17, there were only limited changes to FRS 102 in 2019-20.

More significant amendments are expected from 2022-23, reflecting recent changes in International Financial Reporting Standards, including accounting for financial instruments and leases.

Good Practice Exchange

Audit Wales' Good Practice (GPX) helps public services improve by sharing knowledge and practices that work. Events are held where knowledge can be exchanged face to face and resources shared online. This year the work has focused on COVID-19 learning. Further information on this can be found our website.

Brexit: The United Kingdom's future outside the European Union

The United Kingdom left the European Union on 31 January 2020 under the terms of the Withdrawal Agreement. Between then and 31 December 2020, the UK entered a transition period, during which it continued to participate in EU programmes and follow EU regulations. On 31 December 2020, the transition period ended, and a new relationship between the UK and EU started, on the basis of a new free trade agreement.

The new agreement means some substantial changes in the trading relationship between the UK and the EU. There will also potentially be changes in administrative areas previously covered by EU law. In the short term, the UK has incorporated EU rules into domestic law. However, it is likely than in some key areas, such as public procurement, agricultural support and state aid, the UK will seek to diverge over time. In changing these rules, there will be some important constitutional issues around the relationship between the UK Government and devolved governments.

The wider opportunities and risks for Wales' economy, society and environment will become clearer as public services move from managing the short-term risks, especially around disruption to supply chains, to adapting to a different relationship with the EU and the wider world. We are also awaiting further details on the UK Government's plans to replace EU funding schemes for regional development and rural development.

The Auditor General will continue to keep a watching brief over developments. In November, he wrote to the Chair of the External Affairs and Additional Legislation Committee setting out some observations on the latest position with respect to preparations for the end of the transition period. His letter can be found here. His previous report on public bodies Brexit preparations can be found here with his follow up on progress here.

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Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

GUH – Equipment Procurement Assurance

Final Internal Audit Report

2020/21

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

Reasonable Assurance

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Appendix A Management Action Plan
Appendix B Audit test findings
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Review reference:	SSU_ABU_2021_05.5
Report status:	Final
Fieldwork commencement:	30 November 2020
Fieldwork completion:	22 February 2021
Draft Report issued:	1 March 2021
Draft Report meeting	2 March 2021
Management response:	12 March 2021
Proposed Final Report issued:	15 March 2021
Final Report issued:	17 March 2021
Auditor/s	NWSSP: Audit & Assurance Specialist Services Unit
Executive sign off	Nicola Prygodzicz, Executive Director of Planning, Digital & IT
Distribution	○ Leanne Watkins, Clinical Futures Programme Director ○ Richard Morgan-Evans, Clinical Futures Assistant Programme Director ○ Robert Holcombe, Assistant Finance Director ○ Kelly Jones, Head of Capital Finance ○ Hannah Capel, Senior Programme Manager ○ Richard Howells, Interim Board Secretary
Committee	Audit Committee

ACKNOWLEDGEMENT

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Aneurin Bevan University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Internal Auditors.

1. Introduction and Background

This audit was commissioned in accordance with the agreed Grange University Hospital (GUH) integrated audit plan for 2020/21.

This review has sought to provide assurance that the £27.75m equipment budget was being managed effectively and that the procurement of equipment was progressed in accordance with the UHB and national requirements.

The review had originally been scheduled to take place during July and August 2020, whilst the equipment procurement programme was ongoing, and therefore provide "live" feedback for implementation at the GUH project. However, recognising the significant pressures associated with the early opening in November 2020, management requested that the audit be deferred until after the opening date. Accordingly, the report provides retrospective feedback only.

2. Scope and Objectives

The review was undertaken to determine the adequacy of, and operational compliance with, the systems and procedures of the University Health Board (the UHB), taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.

An objective of the audit was to evaluate the systems and controls in place within the UHB, with a view to delivering assurance to the Audit Committee that risks material to the objectives of the areas of coverage have been appropriately managed.

The scope and remit of the audit included consideration of:

- **Procurement management and control:**
  - The procurement team was adequately resourced and was afforded sufficient time to procure equipment which have a long lead-time;
  - To assess the extent of new purchases v transfers and disposal;
  - Assurance that changes in the procurement timetable arising from Covid-19 or the accelerated programme were appropriately considered at the equipment procurement programme and risk registers; and
  - To ensure that equipment risks were identified and effectively managed.
- **Budget management:**

- Assurance that the equipment budget was adequately monitored, controlled and reported to an appropriate forum.

- **Procurement Sample Testing:**
  - Compliance with SO/SFI and national procurement regulations and controls;
  - Tendering and quotation exercises undertaken to procure equipment were undertaken in accordance with UHB / EU procedural requirements;
  - Single tenders were assessed to demonstrate value for money and were appropriately authorised / reported;
  - Equipment maintenance costs were adequately considered; and
  - Equipment was procured and delivered in accordance with the UHB and SCP's programme requirements.

3. Associated Risks

The potential risks considered in the review were as follows:

- Inadequate control of the equipment budget;
- Poor value for money demonstrated.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the systems of control under review. The opinion is based on the work performed as set out in the scope and objectives within this report.

The equipment procurement programme faced significant pressures during 2020, with two early opening deadlines (partial opening in April 2020 to meet the Covid demand for beds; and the main opening in November 2020, brought forward from March 2021). It is acknowledged that whilst the GUH was available for Covid-related provision, as scheduled in April, it was ultimately not required at that time and no patients were admitted.

Priorities and associated programmes of work were appropriately assessed and adjusted to ensure focus in the right areas; and despite these exceptional pressures, both deadlines were met. Key equipment was procured to enable the safe opening of the hospital on both occasions.

The impact of the early opening on the procurement programme, and procurement routes applied (for example, reduced use of competitive tender / mini-competition exercises), was reported to, and agreed, by the

UHB Board. The report highlighted that the inability to fully test the market by going directly to a single supplier presented the following risks to the Health Board:

- The risk of reduced value for money;
- Potential risk of challenge from other suppliers.

Whilst the procurement approach had to be adjusted to focus on deliverability, as opposed to best value for money (see above), compliance with national and EU procurement regulations was maintained via the utilisation of national NHS frameworks wherever possible. This ensured only pre-approved suppliers were used, and reduced the risk of potential challenge from other suppliers. Mini-competitions were run for the highest value procurements, achieving significant savings from framework list prices, and ensuring best value was achieved at those priority exercises. Despite the significant time pressures, it was pleasing to note that instances of Single Tender / Single Quotation Actions were minimal.

Whilst fully recognising the significant challenges, and the ultimately successful outcome achieved, some issues have been identified in the effectiveness of delivery of the equipment programme:

- Despite clear communications issued from the project team, and escalation to Project Board, insufficient engagement from departments throughout 2019 and 2020 meant the equipment schedule was not finalised (e.g. containing a significant number of inaccuracies), until nearing project completion. This resulted in the submission of a bid to WG for additional funding to the value of £6m in July 2020 and unnecessary ring-fencing of £3m discretionary capital. It is important the UHB reflects on these difficulties and lessons are learnt for the benefit of future projects.
- It was noted that from July 2020, there was no dedicated forum responsible for the monitoring and scrutiny of the equipment programme, despite procurement activity continuing after this date.

Issues were also identified from the sample testing of thirty six procurement exercises e.g.:

- There was an insufficient audit trail at a number of procurement files reviewed (10 of 36) to support the award decision; and
- Whilst all procurement reports lacked sufficient detail to adequately inform the approver of the basis for the award decision, at 4 of 36 exercises in particular, the reports did not explain where deviations had occurred from Standing Financial Instructions.

Noting that the equipment procurement programme was ultimately delivered on time and within its approved budget, supporting the safe and timely opening of the GUH, the equipment procurement arrangements are assessed as providing an overall **reasonable** assurance.

RATING	INDICATOR	DEFINITION
Reasonable Assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the ability of addressing the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Summary of Audit Findings

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Procurement management and control			✓	
2	Budget management			✓	
3	Procurement sample testing			✓	

Design of Systems/Controls

The findings from the review have highlighted **no** issues that are classified as weaknesses in the system control/ design at the project.

Operation of Systems/Controls

The findings from the review have highlighted **7** issues that are classified as weaknesses in the operation of the designed system/control at the project.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan (**Appendix A**) together with the implementation timetable.

Procurement Management and Control

Assurance that the procurement programme was appropriately managed and controlled.

The equipment procurement programme was resourced by specialist procurement officers from NWSSP Procurement Services and a dedicated Project Clinician; and was deemed by management to be sufficient at the time of the review, to deliver the programme. The allocated resources were reviewed and adjusted, as required, to ensure the team could maintain the required momentum throughout the period of procurement. However, management have advised that the allocated procurement resource was

dispersed, earlier than anticipated, following the opening of the facility (see ***Procurement Sample Testing***).

During the period under review, the Procurement team worked with key departments to identify the essential items that would be needed to function on opening; to prioritise the equipment to be procured and transferred (with adjustments to the programme to ensure readiness for each deadline); and to rank the prioritisation of unfunded equipment on the 'unapproved list.' The resulting procurement programme timeline mapped key lead times and enabled the monitoring of progress of delivery.

There was clear reporting, to the Project Board, of key issues and risks affecting the equipment programme each month, including the impact of the Covid emergency on the supply chain and procurement programme.

Ultimately, the programme was delivered successfully and the necessary equipment was procured to enable the hospital to open safely for both the April and November 2020 openings.

However, a number of issues were experienced at the programme, including:

- Insufficient engagement from departments throughout (also raised in the *'Technical Commissioning and Stakeholder Engagement'* audit report (issued June 2020)), resulting in missed deadlines and inaccurate equipment procurement and transfer lists, even during the latter stages of preparation for opening. Whilst these matters were escalated to Project Board, they was no evidence to confirm they were satisfactorily resolved in a timely manner to enable proactive planning of outstanding procurement requirements in the lead up to opening;
- The impact on value for money of only applying full tender or mini-competition exercises to a few procurements, noting insufficient time to run the programme as planned. Whilst noting this approach was agreed by the Board in June 2020, as part of the November early opening decision, the programme of tendering should have already been well underway at this point in readiness for the original opening date of March 2021 (noting the 8-9 month timeframe involved at individual exercises);
- The impact on the UHB's discretionary capital programme of having to ring-fence £3m for unfunded equipment; and
- A bid to Welsh Government for an additional £6m in July 2020 to fund the remainder of the 'essential' equipment list. At the time of reporting, slippage and savings has seen the equipment budget reduce by £1.255m, with £5.580m still to be spent by year end to maintain the agreed Capital Resource Limit (CRL).

These issues should be assessed as part of the ongoing lessons learnt exercise, to inform the delivery of future projects both within the UHB and across NHS Wales (**recommendation 1**).

Noting however that these issues did not impact on the readiness for opening in both April and November 2020, **reasonable assurance** has been determined.

Budget Management

***Assurance that the equipment budget was adequately monitored, controlled and reported to an appropriate forum*.**

It was observed that the equipment budget was regularly monitored and discussed between the equipment team and the Head of Capital Finance, with monthly reporting of the budget and funding position to the Project Board evidenced.

The financial position was monitored via the Equipment Schedule, maintained as a live document by the equipment team and capturing both the approved and unapproved equipment lists, along with indicative (at FBC stage) and actual equipment costs (updated as procurement exercises progressed). Noting the size of this Equipment Schedule, a condensed list or one with separate departmental sub-sections may have been easier to navigate, and this approach should be considered at the lessons learnt review (see **recommendation 1**).

The terms of reference for the Equipment Group included budget monitoring; however, this forum was stood down in July 2020. The Project Board was the only forum thereafter to receive and scrutinise equipment budget information. The continuation of a dedicated equipment forum until project completion may also have assisted with the issues outlined above (**recommendation 2**).

Difficulties in managing an accurate budget, to adequately inform financial forecasting and funding considerations were observed – requiring ring-fencing of discretionary capital and an additional funding bid to WG. However, ultimately, the equipment programme was within its approved funding envelope at the time of reporting; and accordingly **reasonable assurance** has been determined.

Procurement Sample Testing

Assurance that procurements were undertaken in accordance with local, national and EU procurement requirements.

In June 2020 the UHB received Board approval to bring the GUH opening date forward to November 2020 (from March 2021).

The Board's decision was based on a paper which mapped out the impact and risks of early opening, including discussion of the impact on the procurement programme i.e.

- An increased requirement for direct awards (noting reduced timescales and the impact of Covid on the supply chain);
- Associated risk of reduced value for money; and
- Potential risk of challenge from other suppliers.

In order to mitigate these risks, the paper confirmed that:

- the procurement team would use suppliers on frameworks wherever possible; and
- work closely with clinical services on specifications and justification of suppliers.

Compliance with Procedures

The profile of procurements concluded at the time of audit fieldwork (as recorded on the Equipment Schedule provided in November 2020), and the sample selected for audit review, was as follows:

Procurement method	Equipment schedule		Audit Sample	
	Total no. orders placed	Total order value	No. sampled	Value sampled
Tenders	1	£128k	1	£128k
Quotations	6	£159k	4	£135k
Direct award from framework	193	£13,462m	17	£6,479m
Framework mini-competition	22	£10,140m	5	£5,293m
Single Tender / Quotation Action	5	£311k	5	£311k

Discretionary awards	227	£473k	4	£34k
End of year 19/20	8	£631k	-	-
Total	**462**	**£25,304m**	**36**	**£12,380m**

Details of the procurement exercises reviewed are set out at **Appendix B.**

The majority of procurement exercises were undertaken in compliance with the required guidelines.

Framework mini-competition exercises were undertaken for the highest value procurements, with substantial savings reported compared with framework list prices.

Reliance on direct call-off from approved NHS frameworks for the majority of other procurements ensured compliance with procurement regulation and the use of pre-approved suppliers, and enabled deliverability within far shorter timeframes. However, there was no guarantee that value for money was obtained through direct call off from these frameworks, but it is acknowledged that any potential savings forgone cannot be quantified (noting this could only be achieved by testing the market).

However, some issues were noted:

- A clear audit trail was not available from the procurement files provided to sufficiently support the award decision (**recommendation 3**);
- Declarations of interests completed by departmental staff were not available at single tenders/single quotations (**recommendation 4**);
- Procurement reports did not include adequate information to summarise the exercise undertaken; for example, absence of key information such as highlighting non-compliance with SFIs (**recommendation 5**);
- Whilst all approvals had been granted appropriately in line with the project's Scheme of Delegation, there were inconsistencies in the application of the agreed procedure, with unnecessary requests for approval to the Chief Executive / Chair in the majority of cases (**recommendation 6**); and
- Single Tender Actions / Single Quotation Actions were not reported to the Audit Committee in a timely manner (**recommendation 7**).

Whilst noting the above, the volume of orders and pace at which the procurement team were working is acknowledged. The focus on deliverability as opposed to best value (as formally approved) is also

recognised; and the utilisation of approved frameworks assured compliance with procurement regulation and SFIs. **Reasonable assurance** is therefore determined.

7. Summary of Recommendations

The audit findings and recommendations are detailed in **Appendix A** together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	-	6	1	**7**

Finding 1: Lessons Learnt	Risk
Whilst acknowledging the overall success of the equipment procurement programme, i.e. procurement of all high priority items required for opening, to time and within (revised) budget, difficulties were experienced during the delivery of the programme; which may have put these overall objectives at risk. Management have recently completed a lessons learnt exercise which includes feedback from the Project Clinician (responsible for the equipment procurement programme). In addition to those points included in the UHB report, this audit has identified the following issues (and associated impacts) for consideration: • Insufficient engagement from divisions throughout the process. This was observed during the 2019/20 audit when the equipment team were trying to confirm prioritisation of the funded and unfunded equipment lists, and again during this audit as the procurement team sought to finalise procurement and transfer requirements. • The 'early opening' paper submitted to Board in June 2020 reported that, noting the reduced timescales, the UHB would be limited in the number of competitive tender exercises it would have time to run; therefore placing reliance on direct call-offs from established frameworks for the majority of procurements. Noting that at this point tender exercises should have already commenced (recognising the estimated 8/9 month time period required), it is questioned whether the equipment programme was sufficiently advanced, prior to the impact of the Covid-related early opening (April 2020) and the subsequent early opening decision for November 2020.	Future projects may not benefit from lessons learnt from challenges/ difficulties experienced at GUH.

• Management of equipment procured for the April opening (including receipt of deliveries) was undertaken by the Procurement team, diverting their attention from continuing with the main procurement programme. This role may have been better undertaken by a dedicated team separate from the specialist procurement officers, noting it did not require any particular procurement knowledge or expertise. • An external consultant, engaged late in the process, identified a significant number of items not included within the Theatres equipment list. • The significant risk of potentially unfunded essential equipment was mitigated via the ring-fencing of £3m discretionary capital, which had an implication on the UHB's wider discretionary capital programme. • The UHB submitted a bid (July 2020) to WG for an additional £6m to fund the forecast shortfall in the equipment budget. At the time of reporting, the latest Capital Finance paper prepared for the Project Board (March 2021) reported that the equipment budget had been reduced by £1.255m due to slippage and savings (i.e. items costing less than originally forecast). Management have also advised that more additional for transfer were identified than originally anticipated. The paper reported that the remaining equipment budget of £5.580m needed to be spent by the end of the financial year to maintain the agreed Capital Resource Limit, with some items flagged as high risk in terms of deliverability. • The equipment schedule, used as the primary document for equipment prioritisation, procurement management and budget monitoring, was a large and cumbersome document and may have benefited from being broken down into smaller budget headings, for individual focus and management by the equipment team and Finance.	

• There was no formal equipment group (see **finding 2**) in place from July 2020 onwards at which such matters could be coordinated and scrutinised in any detail. Whilst recognising the UHB is unlikely to progress such a large capital project again in the near future, the approach to budget setting, and the timeliness and responsibilities for review and sign-off of procurement and transfer lists, should be reviewed to ensure lessons learnt can be applied for the benefit of future projects.	
Recommendation 1	**Priority level**
Lessons learnt from the management of the equipment programme should be captured, either separately or as part of the formal post project evaluation (**O**).	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. This will be incorporated into post-project evaluation to take on board lessons around equipment for future capital projects.	Senior Responsible Officer April 2021

Finding 2: Equipment forum	Risk
The Equipment Group was established in May 2019 and stood down in June 2020, noting that its original purpose (to review and agree equipment specifications) was deemed to have been concluded. It was noted that the group's terms of reference also included "*financial reporting against the agreed equipment* budget." Since July 2020, there was no dedicated forum operating for the oversight and scrutiny of equipment procurement activity (including prioritisation of procurements, assessment of transfer requirements, delivery of the equipment procurement programme, and budget management). Whilst recognising that the Operational Commissioning Working Group and Service & Operational Commissioning Group operated during this period, their primary purpose was to manage the safe transfer of services to the GUH. This included the transfer and installation of equipment, and not the wider management of the equipment procurement programme. It is acknowledged that a summary update of the equipment programme, including the budget position, was routinely reported to the Project Board. However, a review of minutes, and observations in person, noted that the Project Board did not have sufficient time to direct any degree of scrutiny to this area. Noting the value (in excess of £29m) and significance of the equipment programme, it would have been expected that a dedicated equipment forum would remain in place until the end of the project. Significant issues such as continued lack of engagement from divisions in confirming procurement and transfer requirements (see **finding 1**), would have been best monitored at a	Lack of appropriate oversight and control over a significant project workstream.

dedicated equipment forum – with escalation to the Project Board where necessary.	
Recommendation 2	**Priority level**
At future projects A dedicated equipment group should be in place, with responsibility for oversight of the equipment programme, until it has been fully delivered. The terms of reference and membership should be periodically updated to reflect the current stage of the programme (**O**).	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. In line with internal and audit feedback all stakeholders see the value of a forum such as this and it will be set up for large capital projects.	SRO / Project Director At future projects

Finding 3: Sample testing – Audit trail	Risk
It was noted in the 'November Early Opening' paper submitted to the Board in June 2020, that: "*In order to mitigate these risks* [of reduced value for money and potential risk of challenge from suppliers] *the GUH procurement team will….work closely with clinical services around specifications and justification of suppliers.*" A sample of 36 procurement exercises were examined at this audit review, across the following main categories: • Tenders (1); • Quotations (4); • Direct framework appointments (17); • Framework mini-competitions (5); • Single tenders/quotations actions (5); and • Discretionary awards (4). Procurement folders were provided by NWSSP Procurement Services, for assessment against required standards (including the UHB's Standing Financial Instructions (SFIs) and national procurement guidance). See **Appendix B** for a summary of key findings. It was noted across the sample that some expected elements of the procurement exercises were missing from the files, and additionally were not provided on request. These included:	Future queries / scrutiny / challenge may not be able to be addressed.

• Price submissions from suppliers were not held in the files provided for the following mini-competition exercises: MC003, 264, 269, 273, 274; • Despite procurement exercises in a number of cases involving liaison with suppliers to confirm delivery dates [which in many cases formed the basis of the procurement award decision as opposed to, for example, price], evidence of these communications was not held within the files provided. Management advised that in such cases, recognising the pace of the procurement programme, communication was often held via telephone. Noting however the importance of this information in informing the awards, a file note would be expected as a minimum to confirm the suppliers' positions; and • At the tender exercise sampled (ITT-44236), the majority of documents needed to assess compliance with SFIs were not included in the file provided. Management advised that the Procurement Officer responsible for this tender was away from work at the time of the audit. However, noting the procurement had concluded in March 2020, it would be expected that all files and documents should have been transferred to the central repository. Therefore, whilst the procurement team may have acted appropriately in terms of justification of suppliers (as set out to the Board), there was insufficient evidence retained in the procurement files to support the same. It was also noted that the files were held by NWSSP Procurement Services, as opposed to the UHB. It should be ensured that, on completion of the project, the UHB obtains a copy of the files for future reference if required.	

Recommendation 3	Priority level
a) The equipment procurement files should include a complete audit trail of key documents supporting the award decisions made, including file notes where information was obtained verbally. b) Files should be held centrally in secure folders. c) On completion of the project, all associated procurement files should be retained by the UHB (**O**).	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. There are now conversations taking place between ABUHB and NWSSP to ensure the procurement support to finalise files for future audit trail purposes is completed.	Project Director in conjunction with NWSSP Procurement Services April 2021

Finding 4: Declarations of Interest	Risk
Declarations of Interest (DOIs) for the NWSSP Procurement team were managed centrally in accordance with the NWSSP policy. It was confirmed that DOIs had been submitted for the relevant staff for the period under review. Management advised that DOIs should also be completed by clinical / departmental staff involved in tender exercises, mini-competitions and single tender awards. Completed DOIs were evidenced at the five mini-competition exercises reviewed. However, DOIs were not observed for: • Tender exercise ITT-44236: see previous observations at **finding 3** regarding the incomplete nature of this file in general; and • The five Single Tender Actions (STAs) reviewed: whilst the standard STA proforma incorporates a DOI section, these had only been completed by the Executive Director of Planning, Digital & IT, at the time of approval. DOIs were not observed from the clinical lead/budget holders responsible for making the equipment selections.	Non-compliance with the Standards of Business Conduct Policy. Potential conflicts of interest not identified and managed.
Recommendation 4	**Priority level**
At future projects Declarations of interest forms should be completed as required by departmental staff, and held on the respective procurement files (**O**).	**Medium**

Management Response	Responsible Officer/ Deadline
Agreed.	Project Director / NWSSP Procurement Services At future projects

Finding 5: Procurement Reports	Risk
At all the procurement exercises reviewed, a Procurement Report had been submitted alongside the Request for Approval, to set out the supporting information relevant to the procurement exercise. However, it was noted that, the Procurement Reports did not sufficiently document the process applied or rationale for decisions made required to demonstrate compliance with SFIs and to enable an informed authorisation to be granted. The reports also did not provide tender / quotation values of the successful and unsuccessful bids, to inform the approver of the level of value for money achieved by the award. Whilst this observation applied in general to all the procurement reports reviewed, it was of most significance where an exercise or decision did not follow the standard route, and where SFIs are clear that rationale should be clearly documented before approval is granted. This included: • ITT44357 (Beverage trolleys): whilst over the tender threshold, this exercise had been let as a quotation. Management advised that the required quantities increased after quotations had been received. The procurement report did not explain this; • RFQ-0012 (Tannoy System): this quotation exercise was not compliant with SFIs noting the minimum of 3 quotations had not been obtained. Management advised that reliance had been placed on a prior tender exercise operated by the construction Supply Chain Partner, for which no	Informed authorisations cannot be granted, in line with SFIs.

supporting evidence was available. This was not sufficiently documented within the procurement report; and • RFQ-00011 (Catheter Cabinets) and RFQ-00108 (Lead Aprons): at these two quotation exercises, the awards had not been made to the lowest priced quotations. Management advised that the suppliers for the lower priced quotations could not guarantee deliverability in time for opening. Despite SFIs requiring such instances to be clearly documented and approved, the procurement reports did not provide sufficient clarity. It is recognised that, noting the volume of procurements processed by the team, there may not have been time to document the full information at each report. However, as above, where an exercise does not comply with SFIs, sufficient information should be presented for this to be appropriately approved.	
Recommendation 5	**Priority level**
Procurement reports should sufficiently document the procurement process applied, any anomalies/ deviations from standard practice, and provide a sufficient justification for the decision made (**O**).	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. The rigour around preparing these reports will be carefully monitored in future capital projects and this recommendation feeds well into wider lessons learnt picked up as part of the internal lessons learnt report.	Project Director / NWSSP Procurement Services At future projects

Finding 6: Authorisations	Risk
As above, the Procurement Report was presented alongside the Request for Approval, to obtain written authorisation to each individual procurement exercise. The UHB's Scheme of Delegation has been amended to incorporate GUH approval mechanisms; and granted the Executive Director of Planning, Digital & IT authority to approve GUH project expenditure within the overall project budget and annual Capital Resource Limit. All Request for Approvals reviewed had been signed by the Director of Planning, where required, in line with the GUH Scheme of Delegation. However, at the majority of higher value procurement exercises reviewed, the Request for Approvals had also been signed by the Chief Executive / Chair (in line with the wider UHB Scheme of Delegation). Whilst not posing an issue of non-compliance, this was not in line with the agreement for the GUH and would have placed an unnecessary administrative burden on the Chief Exec / Chair.	Potential non-compliance with the approved Scheme of Delegation.
Recommendation 6	**Priority level**
The UHB should ensure that agreed procedures are implemented appropriately by NWSSP Procurement Services (**O**)	**Low**

Management Response	Responsible Officer/ Deadline
Agreed. Noting that at times the procurement team sought approvals over and above what was required, the Health Board will ensure all key project stakeholders understand where financial approval levels lie.	Project Director / NWSSP Procurement Services At future projects

Finding 7: Single Tender Actions	Risk
Standing Financial Instructions (SFIs) require that all Single Tender and Single Quotation Actions (STAs/SQAs) be reported to the Audit Committee. For the sample of five STAs/SQAs reviewed, three were scheduled to be reported to the February 2021 Audit Committee (and evidenced as such). However, there was no evidence of reporting of the other two (STA-0008 and SQA-0003). It is also noted that the three in February 2021 had been procured in September 2020, and therefore were not being reporting in a timely manner.	Non-compliance with SFIs. Committee scrutiny duties cannot be performed in a timely manner.
Recommendation 7	**Priority level**
Single Tender / Single Quotation Actions should be reported to the Audit Committee in a timely manner, in line with SFIs, to enable effective scrutiny (**O**).	**Low**
Management Response	**Responsible Officer/ Deadline**
Agree – The project appreciates the importance of ensuring timely reporting to the audit committee.	Project Director / NWSSP Procurement Services To the next Audit Committee

Tenders / Quotations

Procurement Ref	Description	Value	Appropriate competition method?	Declaration of Interest [3]	Approval of reduced numbers invited / received?	Maintenance costs considered?	Scoring accurate?	Awarded to highest scorer / cheapest price? [5]	If no, was this formally recorded?	Award appropriately approved?
ABU-GUH-ITT-44236	Heated food trolleys	£127,619	Y - Bravo tender	N [4]	Y	Y	see note [4]	see note [4]	see note [4]	Y
ABU-GUH-ITT-44357	Breakfast & Beverage trolleys	£53,479	N - Multiquote quotation exercise [1]	n/a	n/a appropriate number invited and received	Y	n/a price only	N	Y	Y
ABU-GUH-RFQ-00011	Catheter cabinets	£25,680	Multiquote quotation exercise	n/a	n/a appropriate number invited and received	Y	n/a price only	N	N [6]	Y
ABU-GUH-RFQ 0008	Lead Aprons for X-ray rack	£27,528	Multiquote quotation exercise	n/a	n/a appropriate number invited and received	Y	n/a price only	N	N [6]	Y
ABU-GUH-RFQ-00012	Tannoy system	£27,098	Direct invitation to 2 suppliers [2]	n/a	N	Y	n/a price only	Y	n/a	Y

Notes

[1]Whilst this order value was over the £25k threshold requiring formal tender, management advised that it was run as a quotation exercise with the required quantities being increased after the exercise had commenced. Issues with the accurate identification of equipment requirements have been noted in the main body of the report.

[2]This package of work should have been delivered by the Supply Chain Partner, but was missed in error. The UHB placed reliance on the SCP's tender exercise, for which we are advised only 1 supplier responded. The UHB obtained an additional quotation themselves from an incumbent supplier. Noting this does not meet the SFI requirements for a minimum 3 quotations, and was not addressed in the Procurement Report to enable informed approval, this is deemed non-compliant.

[3]NWSSP Procurement Services advised they obtain Declarations of Interest at tender exercises; not quotation exercises.

[4]A number of documents were missing from this tender file. Management advised the procurement officer responsible was absent from work at the time of the audit, and documents had not been centrally filed so could not be accessed by other staff.

[5]As noted in the main body of the report, in most of the cases reviewed, deliverability in time for opening was the driving factor in the award decision. Often this meant the winning bid was not the cheapest.

[6]The procurement report did not state that the lowest quotation was not successful, or record the reason why. No other documentation was observed on file supporting the outcome.

Framework Mini-Competitions

Procurement Ref	Description	Value	Declaration of Interest	Approved framework?	Maintenance costs considered?	Appropriate evaluation team?	Scoring accurate?	Awarded to highest scorer?	If no, was this formally recorded?	Award appropriately approved?
MC264	CT Scanners	£2,309,461	Y	Y	Y	Y	Y [7]	Y see note [7]	n/a	Y
MC273	Cardiology Cath Lab	£1,454,194	Y	Y	Y	Y	see note [8]	Y see note [7]	n/a	Y
MC269	Digital Radiography room	£922,800	Y	Y	Y	Y	Y [7]	Y see note [7]	n/a	Y
MC272	Fluoroscopy Room	£414,000	Y	Y	Y	Y	Y [7]	Y see note [7]	n/a	Y
MC274	Cath Lab Physiology Monitoring System	£192,660	Y	Y	Y	Y	Y [7]	Y see note [7]	n/a	Y

Notes

[7]Whilst the scoring matrices had been calculated correctly in each case, the supporting price submissions were not included in the files provided. We were unable to verify the accuracy of prices included in the matrices.

[8]At this exercise, the procurement files provided confirmed that four submissions had been received. However, only three had been assessed at the scoring matrix. The file did not provide any supporting evidence as to whether the fourth had been discounted before scoring, and for what reason.

Framework Direct Call-Off

Procurement Ref	Description	Value	Approved framework?	Direct call-off rationale sufficiently documented for approval?	Maintenance costs considered?	Appropriate evaluation team?	Award appropriately approved?
ABU-GUH-DCO-00085	Mindray Patient Monitoring	£1,948,182	Y	Y	Y	Y	Y
ABU-GUH-DCO-00077	Pharmacy Stock Cabinets	£1,557,956	Y	Y	Y	Y	Y
ABU-GUH-DCO-00119	Radiology Ultrasounds	£547,200	Y	Y	Y	Y	Y
ABU-GUH-DCO-00023	Mobile X-Ray	£575,981	Y	N	Y	Y	Y
ABU-GUH-DCO-00115	Mobile C-Arm	£503,064	Y	Y	Y	Y	Y
ABU-GUH-DCO-00133	Ward & Waiting area seating	£311,485	Y	Y	Y	Y	Y
ABU-GUH-DCO-00089	Vascular Ultrasounds	£182,694	Y	Y	Y	Y	Y
ABU-GUH-DCO-00079	Syringe & Volumetric Pumps	£117,000	Y	Y	Y	Y	Y
ABU-GUH-DCO-00106	Dressing Trolleys	£80,311	Y	Y	Y	Y	Y
ABU-GUH-DCO-00112	Microscopes	£173,264	Y	Y	Y	Y	Y
ABU-DCO-GUH-00164	Sterilisation cabinet	£41,760	Y	Y	Y	Y	Y
ABU-GUH-DCO-00146	Spinal Microscope	£151,556	Y	Y	Y	Y	Y

Procurement Ref	Description	Value	Approved framework?	Direct call-off rationale sufficiently documented for approval?	Maintenance costs considered?	Appropriate evaluation team?	Award appropriately approved?
ABU-GUH-DCO-00199	Urology Scopes	£113,359	Y	Y	Y	Y	Y
ABU-GUH-DCO-00156	Doppler	£85,794	Y	Y	Y	Y	Y
ABU-GUH-DCO-00192	Console, saw and drills	£48,349	Y	Y	Y	Y	Y
ABU-GUH-DCO-00053	Patient hoists	£40,996	Y	Y	N [10]	Y	Y
ABU-GUH-Min-0003 [9]	Bariatric Beds & Mattresses	£254,285	Y	Y	Y	Y	Y

Notes

[9]Whilst this procurement was intended to be a mini-competition, the UHB were unable to progress with the intended approach. Whilst 7 suppliers were invited to an initial 'show and tell' day, only one attendee was able to meet the UHB's requirements in terms of specification and deliverability deadlines. This was ultimately concluded as a direct award from the framework.

[10]Maintenance costs were stated as 'to be confirmed' at the Procurement report. Noting this is a relatively low value procurement, and an exception to an otherwise robust practice, a recommendation has not been raised.

Single Tender / Single Quotation Actions

Procurement Ref	Description	Value	Declaration of Interest	Allowable reason for single action?	Maintenance costs considered?	Award appropriately approved?	Reported to Audit Committee?
ABU-GUH-STA-00005	Specialist Racking	£70,125	N [11]	Y	Y	Y	Y (Feb 2021)
ABU-GUH-STA-00002	Rapid Infusors	£106,872	N [11]	Y	Y	Y	Y (Feb 2021)
ABU-GUH-STA-00008	PanoCam	£98,000	N [11]	Y	Y	Y	N
ABU-GUH-SQA-00003	Laryngoscopes	£21,600	N [11]	Y	Y	Y	N
ABU-GUH-SQA-00004	Advance monitors for difficult airways trolleys	£14,400	N [11]	Y	Y	Y	Y (Feb 2021)

Notes

[11]Whilst the declaration of interest (DOI) section of the Single Action proforma had been completed by the Executive Director of Planning, Digital & IT at the time of approval, DOIs completed by clinical / departmental staff, at the time of product selection, were not provided.

Discretionary Awards

Standing Financial Instructions permit awards under £5,000 in value to be let without any competitive exercise undertaken. On the equipment schedule provided, there were a number of items over £5,000 in value, but coded as discretionary. A small sample was reviewed to ensure appropriate processes were followed, with no concerns identified, as follows:

Procurement Ref	Description	Value	'Under £5k Approval Form' approved?	Notes
ABU-GUH-DPO-00169	Clocks	£6,372	Y	The indicative price on the equipment schedule was £4,500. Actual price £5,365 + VAT so only marginally over the SFI threshold. Form approved on that basis.
ABU-GUH-DPO-138	Various	£11,211	Y	This appears to be a sorting error on the equipment schedule. Actual order value was under £5k.
ABU-GUH-DPO-00306 / ABU-GUH-DPO-00307	Soft top & Hard top headlights	£8,758	Y	This was two separate orders. It was confirmed that this was not an example of 'order splitting' to avoid the quotation threshold, with management advising the requirement for the second set of lights from the same supplier was only identified after the first order was placed.
ABU-GUH-DPO-00252	Ceiling light	£7,422	Y	This appears to be a sorting error on the equipment schedule. Actual order value was under £5k.

Assurance Opinion and Action Plan Risk Rating

Substantial assurance - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

Reasonable assurance - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

Limited assurance - The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

No Assurance - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

** Unless a more appropriate timescale is identified/agreed at the assignment.*

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Follow-up of High Priority Recommendations

Final Internal Audit Report

2020/21

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Auditor/s:	James Quance, Head of Internal Audit Stephen Chaney, Deputy Head of Internal Audit Laura Howells, Principal Auditor
Executive sign off	Richard Howells, Board Secretary
Distribution	Executive Team
Committee	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Please note:
This report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.
Our reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Aneurin Bevan University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

The Follow-up of High Recommendations audit was completed in line with Aneurin Bevan University Health Board's (the 'Health Board') 2020/21 Internal Audit Plan. The review sought to provide the Health Board with assurance that high priority recommendations are implemented appropriately and in a timely manner.

The current process for tracking audit recommendations is via an Audit Recommendation Tracker (the 'Tracker'), which is reported to the Audit Committee. Once sufficient progress has been made towards implementing a recommendation, the Executive Team may decide to remove the recommendation from the Tracker.

At the Audit Committee each recommendation included within the Tracker is reviewed, with a status update included over progress made and revisions to implementation dates.

2. Scope and Objectives

The overall objective was to assess the implementation of high priority recommendations that were scheduled for completion by January 2020. If a recommendation has not been implemented as scheduled, we re-assessed the risk and the timeframes to help inform the Health Board's Tracker.

We selected high priority recommendations reported within all audit reports from 2018/19 and 2019/20. In addition, we incorporated the two high priority recommendations from the 2017/18 review of Medical Equipment and Devices.

During our review the impact of the Covid-19 pandemic was taken into consideration. We are aware that the restrictions placed on individuals during the pandemic may have had a detrimental effect in the implementation of these actions. Therefore, we only included recommendations with a completion date prior to the start of the pandemic.

3. Associated Risks

The potential risks considered in the review were as follows:

- high priority recommendations not being implemented in a timely manner resulting in continued risk for the Health Board;
- increased financial, clinical, statutory and reputational risk for the Health Board; and
- inaccurate reporting of recommendation progress within the Tracker.

OPINION AND KEY FINDINGS

4. Overall Assurance Conclusion

As each audit was previously assigned an assurance rating, we have not provided an overall assurance rating for this audit. Instead, we have identified the degree of progress completed regarding each recommendation and provided commentary on the current position.

5. Summary of Findings

We sought an update on whether recommendations had been implemented by the Health Board and supporting evidence to determine if they had been implemented and where it had not, we requested a status update. During the review we experienced difficulty in obtaining the necessary status updates and / or supporting evidence, often with multiple requests required. This may be as a result of inadequate or missing departmental recommendation tracking processes. Consequently, we continue to give limited assurance only over several audits due to a lack of progress. These are identified within Table Two.

We did not receive information for two actions for which we have assumed that no progress has been made. The Health Board should review all recommendations not fully implemented and consider their inclusion onto the Audit Recommendation Tracker. The table below summarises the position.

Table One - Recommendation Summary

Number of recommendations reviewed	20
Number of recommendations fully implemented	5
Number of recommendations partially implemented	12
Number of recommendations not implemented	1
Number of recommendations superseded	2

Where recommendations have not been fully implemented, the Health Board should review each of them and consider inclusion on the Audit Recommendation Tracker, to monitor them until they are fully implemented.

Table Two - Summary of Progress in the Implementation of High Priority Recommendations

Audit Title	Previous Assurance Rating	No. of high priority recommendations	No. fully implemented	No. partially implemented	No. not implemented	Estimated Progress
Charitable Funds (2019)	Reasonable	1	0	1	0	>50%
Divisional Review – Scheduled Care (2019)	Reasonable	1	1	0	0	100%
Fire Safety Follow-up (2019)	Limited	2	1	1	0	>50%
Health and Safety Management (2019)	Limited	2	1	1	0	>50%
Pay Incentives (2019)	Limited	2	0	2	0	<50%
Patient Properties and Monies (2019)	Reasonable	1	1	0	0	100%
Welsh Language Standards (2019)	Reasonable	1	0	0	1	N/A
Budgetary Control including Cost Improvement (2019)	Reasonable	1	1	0	0	100%
Clinical Audit Follow-up (2019)	Limited	3	0	3	0	<50%
Clinical Future – Service Redesign (2019)	Reasonable	2	Superseded			
Management of Balance Sheet Assets (2018)	Reasonable	1	0	1	0	>50%
Well-being of Future Generations (Wales) Act 2015 (2019)	Reasonable	1	0	1	0	>50%
Medical Equipment and Devices (2018)	Limited	2	0	2	0	<50%

Detailed progress for each of the recommendations summarised above is included within Appendix A.

Appendix A: Matters arising from our review of the Health Board's Implementation of High Priority Recommendations

Following our review of the high priority actions selected, we reviewed whether they had been fully implemented. We identified those recommendations which had not been fully implemented and communicated these to management.

Audit Title	Summary of Recommendation	Implementation Progress	Original Implementation Date	Implementation Status
Charitable Funds	Make staff aware of the Charitable Funds Financial Control Procedure (FCP).	The FCP has been updated during April 2020. The Charitable Funds Team is planning to communicate with teams throughout the Health Board by issuing an email incorporating the key points of the FCP. Furthermore, training is to be delivered via Teams by the end of this financial year to update staff on the FCP.	November 2019	Partially Implemented
Divisional Review – Scheduled Care	Policies and procedures owned by the directorates should be managed in local registers. A process should be established to	A procedure has been established, setting out the file structure for each type of procedural document (e.g. clinical futures, operational, workforce etc.).	November 2019	Fully Implemented

Audit Title	Summary of Recommendation	Implementation Progress	Original Implementation Date	Implementation Status
	address document refreshes and control weaknesses.			
Fire Safety Follow-up	Fire manuals to be prepared for all sites.	We saw evidence of detailed monitoring over the completion of fire risk assessments / manuals. However, whilst progress has been made, some areas are still outstanding. The impact of the pandemic has delayed this further but is anticipated to be progressed by the end of March 2021.	January 2020	Partially Implemented
Fire Safety Follow-up	The fire safety dashboard information should serve as a tool for assessing the current performance levels	Additional resource has been recruited to specifically develop and manage a fire safety dashboard. The dashboard has been completed and is used for reviewing compliance and performance.	January 2020	Fully Implemented
Health and Safety Management	Regular workplace inspections should be completed.	A health and safety monitoring programme for 2019/20 was developed and implemented. The monitoring included both management audits and inspections. 77 of 88 management	December 2019	Partially Implemented

Audit Title	Summary of Recommendation	Implementation Progress	Original Implementation Date	Implementation Status
		audits were completed and 42 out of 52 inspections were completed. Since the start of the pandemic, audits and inspections have paused, but expected to restart by the end of March 2021.		
Health and Safety Management	The Health Board should urgently ensure risk assessments are completed for each area.	All divisional risk registers have been successfully uploaded to the Datix system. These are monitored via the ABUHB Health and Safety Committee and ABUHB Quality and Patient Safety Operational Group.	January 2020	Fully Implemented
Pay Incentives	Additional session payments to be restricted to standard levels, but where this is not possible an approved schedule of enhanced rates ratified by the Executive Team should be maintained.	We were informed that the Executive Team has agreed to complete this in line with the annual planning cycle, to address any capacity gap (where waiting list initiatives is utilised as part of the solution). This is expected to commence during early April 2021.	September 2019	Partially Implemented
Pay Incentives	For the non-automated process	Three divisions have been identified where the new process should be	September 2019	Partially Implemented

Audit Title	Summary of Recommendation	Implementation Progress	Original Implementation Date	Implementation Status
	only, consultants should submit signed claim forms for all additional sessions they are claiming payment for.	embedded. Within one division the process has been established, the second has received training and the final division has been delayed due to Covid-19.		
Patient Properties Management	The Health Board should develop an information sheet which captures the key sections from the Financial Control Procedure (FCP) and compliance should be monitored.	We were informed that a high-level information sheet was developed for each ward. Visits to the ward took place commencing January 2020, with most completed by March 2020, when the pandemic commenced.	December 2019	Fully Implemented
Welsh Language Standards	The Welsh Strategic Group should monitor and escalate non-compliance or delays with the delivery of the Standards implementation to	No information has been provided	January 2020	Not Implemented

Audit Title	Summary of Recommendation	Implementation Progress	Original Implementation Date	Implementation Status
	the Executive Team. There is suitable representation, to include all divisions within the group.			
Budgetary Control including Cost Improvement	Directorate budget monitoring meetings take place monthly. The Scheduled Care division financial review process is re-assessed.	We were informed that directorates are meeting monthly (prior to the pandemic) and that notes, and actions are documented. We have seen escalation of key points from the directorates to the Finance and Performance Committee. There is a review underway over the monthly reporting arrangements to ensure they are appropriate.	January 2019	Fully Implemented
Clinical Audit Follow-up	The Health Board should develop a Quality and Patient Safety Improvement Strategy and Assurance Framework.	A review has commenced over the end to end process of the clinical audit programme and the assurance framework.	November 2019	Partially Implemented
Clinical Audit Follow-up	The Health Board is required to	A review has commenced over the end to end process of the clinical	September 2019	Partially Implemented

Audit Title	Summary of Recommendation	Implementation Progress	Original Implementation Date	Implementation Status
	participate in a certain level of clinical audit. It is necessary to have appropriate governance and reporting structures in place to support this.	audit programme and the assurance framework.		
Clinical Audit Follow-up	Divisional Directors are responsible for maintaining the overview of local clinical audits, linked to clinical risks and a process should be implemented to ensure appropriate accountability within the divisional clinical audit process.	A review has commenced over the end to end process of the clinical audit programme and the assurance framework.	November 2019	Partially Implemented
Clinical Futures – Service Redesign	A plan should be developed to ensure that all	N/A – action superseded	March 2019	N/A

Audit Title	Summary of Recommendation	Implementation Progress	Original Implementation Date	Implementation Status
	clinical model assumptions, variables, requirements and business cases are appraised.			
Clinical Futures – Service Redesign	There should be a documented trail of what is required for each action identified from the Challenge and Support process.	N/A – action superseded	April 2019	N/A
Management of Balance Sheet Assets	The Health Board should introduce tagging / identity marking of all relevant assets.	We were informed that the Health Board is currently implementing a passive RFID asset tagging system called RFID Discovery. The system allows each asset to be tracked by attaching a pre-printed RFID label. This uniquely identifies each asset. The pandemic has paused asset tagging, but there is a revised implementation timeframe of some directorates being completed by the end of 2021/22.	March 2019	Partially Implemented

Audit Title	Summary of Recommendation	Implementation Progress	Original Implementation Date	Implementation Status
Well-being of Future Generations (Wales) Act 2015	The Programme Board should review its objectives and the progress against them as part of its agenda and should be chaired by the Executive Lead.	The ten wellbeing objectives have been reviewed by the Public Partnerships and Wellbeing Committee, alongside the IMTP process. However, further work is underway to enhance the monitoring of the objectives, with an engagement workshop across the Health Board taking place during March 2020. However, due to the pandemic this process has temporarily paused.	December 2019	Partially Implemented
Medical Equipment and Devices	Registers should be maintained identifying all key equipment and devices, with the necessary details retained to manager the items.	The Health Board has invested in a new Medical Electronics (EBME) database - Softpro Medusa Equipment Management. Alongside this is the operation of a radio-frequency identification (RFiD) physical asset tracking system, which will allow ward and departmental managers to access up-to-date information over the medical equipment and devices that they use. This is currently being rolled out across the Health Board.	No date provided	Partially Implemented

Audit Title	Summary of Recommendation	Implementation Progress	Original Implementation Date	Implementation Status
Medical Equipment and Devices	Where devices require training these should be identified and training compliance monitored, with appropriate action undertaken where required.	Whilst training compliance has improved on the corporate led training (infusion devices), it still ranges between 45% and 81% during 2020/21. The impact of Covid-19 has reduced training capacity. To resolve this, an escalation process will be developed, with monthly reports highlighting poor compliance. Using this information targeted training sessions will be operated. Where local, specialist training is required (e.g. within theatres), the early opening of the Grange University Hospital has affected current progress, but work is underway to address this. Integration with the equipment database is being considered.	No date provided	Partially Implemented

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Review

The review was undertaken using a risk-based methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the health board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

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Shared Services Partnership
Audit and Assurance Services

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

High Voltage Electrical Systems Management

Final Internal Audit Report

2020/21

Aneurin Bevan University Health Board

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Audit and Assurance Services

Reasonable Assurance

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

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Committee	Audit Committee

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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1. Introduction and Background

High voltage (HV) in healthcare premises is governed by the Welsh Health Technical Memorandum (WHTM) 06-01 (*Electrical Services Supply and Distribution)* and Health Technical Memorandum (HTM) 06-03: (*Electrical safety guidance for high voltage systems).*

The University Health Board's (UHB) High Voltage Operational Policy has been published as a practical implementation of HTM 06-03; in addition to providing sufficient coverage for the UHB to comply with the principal legislation relevant to HV systems – Electricity at Work Regulations 1989. Additional information is contained within the Corporate Health & Safety policy.

A site visit was undertaken to St. Woolos Hospital (STW) for this audit, to review available site and substation records for both STW and the Royal Gwent (RGH) Hospital, and to assess compliance with the record keeping requirements of HTM 06-03.

2. Scope and Objectives

The review was undertaken to determine the adequacy of, and operational compliance with, the UHB's systems and procedures, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.

An objective of the audit was to evaluate the systems and controls in place within the UHB, with a view to delivering reasonable assurance to the Audit Committee that risks material to the objectives of the areas of coverage were appropriately managed.

In preparing the scope of work, we were mindful of the work performed by NHS Wales Shares Services Partnership: Specialist Estates Services (NWSSP:SES) on an annual and tri-annual basis, and have sought to avoid any potential duplication. Whilst this audit revisited some areas assessed by NWSSP:SES, our work was supplementary, e.g. by extending testing across a wider sample, and sought to ensure the appropriate monitoring, reporting and timely implementation of previously raised NWSSP:SES recommendations.

Accordingly, the scope and remit of the audit included:

- **Governance arrangements**, including policies and procedures, roles and responsibilities, training, the remit and operation of the Electrical Safety Group (ESG) and linkage to the Board;
- **Risk management**, including the appropriate assessment of HV risks on UHB premises;
- **Central monitoring and reporting**, including hazard notices; incidents; maintenance, inspection and audits; and

- **Performance of works**, including safety programmes, permits to work, safety, supervision and compliance with the standards.

3. Associated Risks

The potential risks considered in the review were as follows:

- harm and death;
- breach of duty of care;
- liabilities and employment impacts;
- fines, charges and court costs;
- adverse service impact and associated costs; and
- adverse publicity for the UHB.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

Management have confirmed there have been no HV-related health and safety incidents in recent years.

Sound operating procedures were evidenced in a number of areas, including:

- A High Voltage Operational Policy aligned with the requirements of HTM 06-03;
- Appropriately trained and appointed Authorised Persons, sufficient in number to cover the UHB's sites with HV infrastructure;
- Established structures for the governance and management of statutory compliance matters, including HV;
- Sound risk assessment, recording and monitoring processes, coupled with a substantially reduced electrical supply risk in critical care areas noting the transfer of the majority of such to the Grange University Hospital (GUH);
- Robust contract management processes operating in respect of the appointed HV maintenance contractor; and

- Generally appropriate record keeping and management control over HV works.

Recognising the exceptional pressures faced by the UHB in the past 12 months, both from the Covid pandemic and the prioritisation of the early opening of the GUH, some variances to the established good practice arrangements were observed. As a result, a number of recommendations have been raised, see **Appendix A**.

Further, formal independent assurance provided by NWSSP:SES in their role as Authorising Engineer (AE), as required by HTM 06-03, was placed on hold, with tri-annual site visits becoming overdue in 2020. The prioritisation of the early opening of the GUH was agreed between the UHB and NWSSP:SES. However, the AE maintained involvement in assessing and approving Authorised Persons and attending the Electrical Safety Group. Site visits are now planned for 2021.

In the context of the above, **Reasonable Assurance** has been determined in the management of high voltage electrical systems.

RATING	INDICATOR	DEFINITION
Reasonable Assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Governance			✓	
2	Risk Management				✓
3	Central Monitoring & Reporting			✓	
4	Performance of Works			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the audit have highlighted **1** issue that is classified as weaknesses in the system control/design for the management of high voltage electrical systems.

Operation of System/Controls

The findings from the audit have highlighted **5** issues that are classified as weaknesses in the operation of the designed system/control for the management of high voltage electrical systems.

6. Summary of Audit Findings

Governance

That appropriate HV governance arrangements (complying with national guidance/requirements) are applied.

The UHB's High Voltage Operational Policy (updated and approved in 2019), complying with the requirements of HTM 06-03, was evidenced. Noting recent changes affecting HV management (including the opening of the GUH and the introduction of new Authorised Persons (APs)), the policy was being reviewed and updated at the time of the current audit.

During the course of the financial year, recognising previous recommendations made by NWSSP:SES, and the management requirements for the newly opened GUH, the UHB had increased the number of its HV APs from two to five (with a further officer awaiting

training). This provides improved coverage and expertise across the UHB estate. All appropriate documents and training certificates were in place, and held centrally in the MICAD system. A training matrix was in place to monitor APs across all compliance areas.

WHTM 06-01 requires the UHB to operate an Electrical Safety Group, demonstrating suitable '*governance, competence and accountability arrangements for the provision of safe electrical systems in healthcare premises.'* The UHB meets this requirement through the overarching Statutory Compliance Group and the Electrical Safety Sub-Group.

However, the frequency of both Groups' meetings was reduced during 2019-21; the Covid emergency and the delivery of the GUH project also impacted during that time.

The NWSSP:SES Authorising Engineer's annual report (issued March 2021) concluded that the UHB's arrangements for an Electrical Safety Group were satisfactory, however this report recommends enhancements to improve the existing governance arrangements (**recommendation 1**).

Reasonable assurance has been determined in this area.

Risk Management

That HV risks have been appropriately assessed.

The UHB's HV risks were appropriately reported in the following:

- Quality & Patient Safety Operational Group Divisional Risk Register - in respect of the risk of loss of electrical supply to critical areas; and
- Estates & Facilities Backlog Maintenance Risk Register - in respect of improvements needed to the HV infrastructure.

Whilst the electrical supply risk had previously been considered on the Corporate Risk Register, the risk has been significantly downgraded with the opening of the GUH (noting that the hospital has been designed to provide maximum resilience in terms of HV supply).

Older sites with ageing HV infrastructure previously posed a greater risk noting critical patients were treated at those sites. These sites have now been downgraded to enhanced Local General Hospitals, removing the critical nature of their electrical supply needs.

Recommendations relating to the resilience / risk of the HV infrastructure have previously been made by NWSSP:SES. Where additional funding is required to address these matters, issues are logged on the above Backlog Maintenance Risk Register and discretionary capital funding has been requested but not yet allocated.

Whilst the Statutory Compliance Group has a role in risk management, the Group had not met since September 2019 (see **recommendation 1**).

Recognising the up to date risk registers, the consideration of input from external sources in terms of resilience risks, and the significant reduction in electrical supply risk with the opening of the GUH, **substantial assurance** has been determined.

Central Monitoring & Reporting

That appropriate arrangements are in place for the monitoring and reporting of hazard notices, incidents, maintenance, inspection and audits.

Management has confirmed that there have been no HV-related health and safety incidents on its premises for many years.

High Voltage Hazard Alerts (HVHAs) are issued by the Welsh Government (WG), to all Chief Executives in Wales, and published on the NWSSP:SES website. HVHAs should be reviewed by Works & Estates in a timely manner to assess for relevance to the UHB's HV infrastructure, and take appropriate action where required.

During 2020, the UHB was omitted from the WG email communications issuing the HVHAs, and did not receive any issued after May 2020. The NWSSP:SES website had not been checked in the meantime, resulting in a number of missed HVHAs which were only identified in January 2021. It was noted, however, there had been no significant implications for the UHB arising from the missed HVHAs (**recommendation 2**).

The UHB has appointed a maintenance contractor to deliver its HV maintenance requirements, together with its repair and emergency call out needs. Robust contract management controls were evidenced, via the recently introduced Estates Contract Management team, with technical oversight from the APs.

Independent assurance of HV activities was provided via the UHB's appointed Authorising Engineer (AE) (NWSSP:SES). HTM 06-03 requires annual reviews by the AE of AP competency, with three-yearly audits of each HV site. At the date of reporting, whilst an annual audit report had been published (March 2021), the most recent site visits had taken place in 2017 and were therefore out of date.

Management confirmed that the Covid impact across NHS Wales, coupled with the commitment between the UHB and NWSSP:SES to prioritise the completion of the GUH in readiness for early opening, meant that routine AE duties have had to be postponed. However, the AE has remained involved with the UHB's HV systems, approving / re-approving all current

APs in the past year, and attending the ESG in October 2020. Accordingly, no recommendation has been made.

Noting a number of actions from the 2017 NWSSP:SES report remain outstanding (subject to receipt of requested funding), an audit / recommendation tracker has been recommended to facilitate improved monitoring and reporting of NWSSP:SES and other audit recommendations (**recommendation 3**).

The site visit to STW, to review available site and substation records for both STW and RGH, found that records were largely controlled as required. However, some minor record-keeping improvements have been recommended (**recommendation 4**).

In the context of the above, **reasonable assurance** has been determined in this area.

Performance of Works

That appropriate arrangements were in place for HV works, including Safety Programmes, Permits to Work, Limitation of Access etc.

HTM 06-03 sets out strict requirements for the management of HV works, including the use of Safety Programmes, Permits to Work, Sanctions for Test and Limitation of Access forms – to ensure works have been appropriately risk assessed, managed and signed off.

Records were reviewed at the sampled sites of STW and RGH. Whilst noting very few jobs had taken place requiring the above controls in the past two years, the majority of required paperwork had been appropriately completed and referenced within the site log books.

However, one Limitation of Access (LOA) form had not been signed on completion of the works. Additionally, LOA forms had not been used to control relevant maintenance jobs undertaken by the appointed maintenance contractor.

The HV Operational Policy requires review in relation to its requirement for additional narrative to be included on the LOA forms, which was currently not being met (**recommendations 5 & 6**).

Recognising the otherwise robust controls evidenced, **reasonable assurance** has been determined in this area.

7. Summary of Recommendations

The audit findings, recommendations are detailed in **Appendix A** together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations raised	-	3	3	**6**

Finding 1: Governance – Electrical Safety Group	Risk
Welsh Health Technical Memorandum (WHTM) 06-01, 'Electrical Services Supply & Distribution (2018),' at section 3, sets out that: *"Each healthcare organisation, through its Electrical Safety Group, should be able to demonstrate that they have suitable governance, competence and accountability arrangements in place to provide safe electrical systems in healthcare premises.* *The Electrical Safety Group is a multidisciplinary group formed to assess all aspects of electrical safety and resilience required for the safe development and operation of healthcare premises."* The required role and responsibilities of an Electrical Safety Group (ESG), as above, are split in the UHB between two groups: the Statutory Compliance Group (SCG) and the Electrical Safety Sub Group (ESSG). The SCG has a more senior membership and operates at a higher governance level (akin to the requirements set out in WHTM 06-01), but splits its time between all areas of statutory compliance. The ESSG is an operational-level group and focuses on technical matters specific to Low and High Voltage electrical safety. When considering the intended function of the two groups together, based on their respective terms of reference (ToR), the majority of requirements recommended by WHTM 06-01 would be covered. However, some issues were noted:	Non-compliance with WHTM 06-01. Potential insufficient oversight and scrutiny of HV matters.

• Neither forum has met with the required frequency as set out in the ToR, in the last few years. The last meeting of the SCG was in September 2019, and the last meeting of the ESSG in October 2020 (with no meetings in the year prior); • The ESSG does not have its own electrical-specific terms of reference (only a generic ToR for all sub-groups). Members were seen to be discussing the need for a standard agenda at the October 2020 meeting; • There were some gaps in recommended membership between the two groups e.g there was no clinical representation at either forum; • Only a brief verbal update from the ESSG was referenced in SCG minutes. This does not provide assurance that the SCG was sighted on the key areas of responsibility recommended at the WHTM, to enable effective scrutiny; and • When minutes of the SCG were requested to demonstrate approval of the HV policy (in 2019), they could not be located. It is also acknowledged, in determining the priority level of this issue, that Works & Estates has a strong management structure in place with assurance given that significant issues would be reported immediately, through the existing operational management structure, as required.	
Recommendation 1	**Priority level**
The function and memberships of the Statutory Compliance Group and Electrical Safety Sub-Group should be reviewed to ensure: a) Both groups meet with the required frequencies set out in their Terms of Reference;	**Medium**

b) Responsibilities and memberships across the two groups meet the recommendations of WHTM 06-01; c) An electrical-specific Terms of Reference, or as a minimum, a standard agenda, is developed for the Electrical Safety Sub-Group and approved by the SCG; d) A written report be submitted by the ESSG to each SCG meeting, providing assurance on the key areas of compliance required by HTM 03; and e) Minutes from all meetings should be retained for future reference, in line with the UHB's agreed document retention policy and WHTM/HTM requirements (**O**).	
Management Response	**Responsible Officer/ Deadline**
Agreed. The next meeting of the ESG has now been scheduled for 24th March 2021.	Head of Estates (Maintenance & Operations) June 2021

Finding 2: Central Monitoring & Reporting – Hazard Alerts	Risk
High Voltage Hazard Alerts (HVHAs) are issued by the Welsh Government (WG), to all Chief Executives in NHS Wales, and published on the NWSSP:SES website, where relevant issues have been detected that may impact the NHS Wales estate. A sample of HVHAs issued during 2020 was selected for audit review. It was confirmed that all were held by Works & Estates, and had been reviewed by the AP for relevance to the UHB. However, the AP advised that HVHAs issued after May 2020 (32 in the period under review) had not been communicated to the UHB via the established email communication link. This was only detected in January 2021 when the AP checked the NWSSP:SES website for relevant HVHA's. It was confirmed that the UHB has now been added back in to the communications link and all HVHAs retrospectively reviewed. It was noted that there have been no significant implications for the UHB arising from these HVHAs. It was noted from the minutes of the Statutory Compliance Group meeting in September 2019, that the department was to regularly check the NWSSP:SES website for issued HVHAs. Had this been undertaken on a more regular basis, the issue would have been identified sooner.	The UHB may not be aware of relevant HV risks which may affect their infrastructure. Staff safety may be at risk / increased risk of loss of electrical supply if a system fails.
Recommendation 2	**Priority level**
The NWSSP: SES website should be periodically checked to ensure Works & Estates are in receipt of all relevant hazard notices (**O**).	**Low**

Management Response	Responsible Officer/ Deadline
Agreed, the website will be periodically checked from now on. The omission was not the fault of the UHB, and further we would normally expect input from NWSSP:SES to provide additional assurance in this area. Under normal circumstances, we would also monitor alerts for reporting to the Statutory Compliance Group / ESG (as discussed above).	Head of Estates (Maintenance & Operations) Immediate

Finding 3: Central Monitoring & Reporting – action tracking	Risk
The Works & Estates department receives assurance reports from a number of sources, including NWSSP:SES and Internal Audit, both of which raise recommendations for action by management. As set out in its terms of reference, the Statutory Compliance Group (SCG) is responsible for receiving assurance reports. It was noted in the September 2019 minutes that members agreed that recommendations from the audit reports would be extracted and distributed for monthly updates, to ensure they have been actioned (particularly noting some time had passed since the last round of NWSSP:SES audits undertaken in 2017). It was, however, confirmed that such a tracker system has not yet been implemented (recognising the aforementioned pressures and priorities of the department in the last year). Management confirmed that a number of actions recommended in the last round of NWSSP:SES reports have been implemented, with others awaiting funding. Whilst recognising, as highlighted in **finding 1,** that the SCG has not met for 18 months, on re-initiation of meetings it should be sighted on progress towards previously received recommendations.	Recommendations received, which may relate to non-compliances or resilience issues, may not be appropriately actioned in a timely manner.
Recommendation 3	**Priority level**
a) An audit / recommendation tracker should be put in place, to monitor the status of compliance-related recommendations received. b) Progress should be monitored at the Electrical Safety Sub-Group (and other sub-groups as appropriate), and reported to the Statutory Compliance Group (**O**).	**Medium**

Management Response	Responsible Officer/ Deadline
Agreed, an action tracker will be implemented. We recognise this may also facilitate funding allocations.	Head of Estates (Maintenance & Operations) June 2021

Finding 4: Central Monitoring & Reporting - Records	Risk
A site visit was undertaken to St. Woolos Hospital (STW), to review available site and substation records for both STW and Royal Gwent Hospital (RGH), and to assess compliance with the record keeping requirements of HTM 06-03. The following minor house-keeping compliance issues were observed: • Whilst the Operational Procedure and Operations and Maintenance manuals were held on site in a locked metal cabinet as required, the contents of both files were significantly out of date (including e.g. the absence of current Hazard Alerts i.e. only copies of Hazard Alerts from the 1990s were present). • The site/substation combined log books at STW and RGH did not meet the standard required, noting they were not hard backed or sequentially numbered. • There was no record in the log books of any AP inspection activities taking place. Management advised that the requirement for 3-monthly AP site inspections would be captured under general visits (as seen to be regularly recorded in the log books), and not recorded specifically as an inspection visit. Further, whilst noting requirements for annual AP inspections of safety, test and portable earthing equipment, the AP advised that these are either managed via replacement of low value items on an annual basis, or by the appointed HV contractor, who manages their own equipment. Site records however did not capture this information. It was acknowledged the above issues are minor in nature, and relate to house-keeping matters that would not affect the safety of the HV system. Whilst a	Non-compliance with the HTM. Documents not available on site if required.

number of required current documents were not available on site, they have all been provided electronically as part of the audit. However, to ensure compliance with the HTM, and that key documents are available on site if required, the above should be reviewed and compliance with national guidance demonstrated. The introduction of a new HV site (the Grange University Hospital) along with the newly appointed APs, make this an opportune time to review and refresh house-keeping arrangements to ensure best practice going forward.	
Recommendation 4	**Priority level**
a) Operational Procedure and Operations & Maintenance files should be reviewed, with out of date documents archived and current documents filed, as required by HTM 06-03. b) Site/substation log books should be maintained in the format required by HTM 06-01 (section 8). c) Records of inspections / replacement of equipment for which the UHB is responsible for should be maintained in the HV files (**O**).	**Low**
Management Response	**Responsible Officer/ Deadline**
Agreed, we recognise the benefits of improved record keeping, to make current documents more accessible.	Head of Estates (Maintenance & Operations) June 2021

Findings 5 & 6: Performance of Works – Limitation of Access	Risk
As part of the site visit to STW, control paperwork (Safety Programmes, Permits to Work, Sanctions for Test and Limitations of Access), was reviewed to ensure compliance with the standards required by HTM 06-03, in the management of HV-related works. The UHB utilised formal, pre-printed duplicate books (with sequentially numbered pages) published by the Department of Health for these key documents. Noting the small number of HV jobs taking place, the current books had been in use for a number of years, and were only partially complete. All books were securely held in a metal, locked cabinet. It was noted however that the UHB's HV Operational Policy requires that the Limitation of Access (LoA) forms include a printed copy of para 4.23-4.29 of HTM 06-03, and the statement "*the CP (HV) must NOT touch or interfere with the HV system.*" Noting the LoA book was standardised and printed by an external source, these references were not included. It is also unclear how this requirement would be achieved using the current standardised books. The Policy requirements should therefore be reviewed and reconsidered, with an alternative mechanism for providing this additional control, should it still be considered relevant by management. The following issues were also noted from the review of documents on site: • One LOA form (06/08032) had not been signed by the contractor or AP on completion of the works. Management advised that the contractor left site before the work could be signed off. Noting this was an exception to otherwise good practice, and management advise the matter was reported	Non-compliance with UHB policy / HTM 06-03.

to the main HV contractor (who provided the contractor involved), no recommendation has been made; and • One element of the maintenance contractor's annual maintenance schedule (circuit breaker protection trip testing), would require use of the Limitation of Access forms to control the work. However, for the period reviewed (March 2020 to date), the relevant paperwork had not been completed for STW or RGH.	
Recommendations 5 & 6	**Priority level**
5. The UHB's HV policy requirement for inclusion of specific wording on the Limitation of Access forms should be reviewed, and removed if no longer considered feasible / necessary (**D**).	**Low**
6. Limitation of Access forms should be used where appropriate for work undertaken by the maintenance contractor (e.g. circuit breaker protection trip testing) (**O**).	**Medium**
Management Response	**Responsible Officer/ Deadline**
5. Agreed. We have reviewed the policy and agree the reference will be removed. 6. Agreed. Appropriate documents will be in place from now on for relevant works.	Head of Estates (Maintenance & Operations) 5) June 2021 6) Immediate

Appendix B: Audit Assurance Ratings

Substantial assurance - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

Reasonable assurance - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

Limited assurance - The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

No Assurance - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment

Client Organisation	Aneurin Bevan University Health Board
Audit title	High Voltage Electrical Systems Management
Audit reference	SSU ABU 2021 03
Final Report Date	24th March 2021
Auditor(s)	Melanie Goodman

I would be very grateful if you would please take a moment to complete the below questionnaire which will enable us to ensure that we provide a high quality service. Feedback will also be also reflected within our key performance information reported to the Audit Committee.

	QUERY (enter "X" alongside)	Yes	No	Partially	n/a	Any further comments
1	**Engagement & Communication** Were you satisfied with the way the audit team engaged with you and colleagues?					
2	**Professionalism** Was the audit conducted in a positive, professional manner and respectful of your work commitments?					
3	**Report** Was the work reported in a clear, constructive way?					
4	**Impact** Was the audit beneficial eg providing assurance regarding current arrangements, or supporting improvements?					

What words would you use to describe the audit service you have received? Please feel free to enter up to six words into the boxes below:		

If you have any additional comments or suggestions, please add them below:

Thank you very much for taking time to complete this questionnaire. Please return by email: huw.richards@wales.nhs.uk or post: **Huw Richards, Deputy Director (SSU), NWSSP Audit & Assurance, Floor 3, Companies House, Crown Way, Cardiff, CF14 3UB**
Alternatively, please feel free to call me on: **029 2090 5312**

GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau Gwasanaethau Archwilio a Sicrwydd | Shared Services Partnership Audit and Assurance Services

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Hospital Sterilisation and Disinfection Unit (HSDU) Project

Final Internal Audit Report

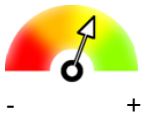
2020/21

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

Reasonable Assurance



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Appendix A Management action plan
Appendix B Follow up of previous recommendations
Appendix C Audit assurance ratings

Review reference:	SSU_ABU_2021_01
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Auditor/s	NWSSP: Audit & Assurance Specialist Services Unit
Executive sign off	Nicola Prygodzicz, Director of Planning & Performance
Distribution	Andrew Walker, Strategic Capital & Estates Programme Director Kelly Jones, Head of Capital Finance Richard Howells, Interim Board Secretary
Committee	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Internal Auditors.

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Aneurin Bevan University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

This audit was undertaken in order to evaluate the processes and procedures that support the delivery of the Hospital Sterilisation & Disinfection Unit (HSDU) project at the new Grange University Hospital (GUH) site.

The Outline Business Case (OBC) set out a case for change to develop a configuration of Hospital Sterilisation and Disinfection Unit (HSDU) services that supports the implementation of the Clinical Futures Programme and the development of the Grange University Hospital (GUH), which is now operational.

The OBC outlined a capital cost of circa £15m, and was approved by Welsh Government (WG) in January 2019.

Enabling works (demolition of the existing canteen building) were approved by the Welsh Government in August 2019 in the sum of £0.404m. The works were completed in January 2020.

The FBC was submitted to the Welsh Government on 30 September 2019 with approval for £15.770m received on 11 December 2019. Work on site commenced in February 2020; with planned completion June 2021.

This will be the second audit of the project, with the 2018/19 review determining reasonable assurance.

2. Scope and Objectives

The review was undertaken to determine the adequacy of, and operational compliance with, the University Health Board's (UHB) systems and procedures, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.

The objective of the audit was to evaluate the systems and controls in place within the UHB, with a view to delivering reasonable assurance to the Audit Committee that risks material to the objectives of the areas of coverage were appropriately managed.

The scope and remit of the audit sought to assess the delivery within the time, cost and quality parameters in the following areas:

- **Follow up** of previously agreed recommendations (see Appendix B);
- **Design Development:**
  - Assurance that the design was sufficiently progressed and signed off by users in accordance with the development programme;
  - Assurance that the users were adequately supported with professional advice;

- Assurance that operational policies and critical care pathways were fully considered and incorporated into the design solution;
- Assurance that the design was sufficiently developed at the target cost; and
- Assurance that equipment requirements were fully considered within the design development and prior to the commencement of works on site (e.g. compliance with HTM requirements).

- **Target Cost / Valuation:**
  - Assess the processes applied to challenge the build-up of the target cost;
  - Assess the processes established to evaluate the initial tender packages prior to approval and the extent of benchmarking undertaken;
  - Assessment of the SCPs risk assumptions built into the target cost;
  - Confirmation that appropriate approvals were in place to accept the target cost; and
  - Appropriate interim valuation arrangements were applied at the project.
- **Enabling Works:**
  - Appropriate contractual arrangements were in place for the enabling works; and
  - The enabling works were delivered within time, cost and quality parameters.
- **Change Management:**
  - Assurance that changes were processed/authorised in accordance with the contract and local internal control procedures.
- **Working Safely during Coronavirus (Covid-19):**
  - Assurance that the financial and delivery implications of procurement and contractual issues (both pre & post Covid) were appropriately managed; and
  - To ensure that safe working practices were established and monitored.

3. Associated Risks

The potential risks considered in the review were as follows:

- The target cost did not provide sufficient value for money;
- Appropriate approvals were not in place;
- The project was not effectively managed; and
- Project over-runs on time and cost.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

At the date of the review, the HSDU project had experienced some significant issues which have had both financial implications (significant draw on the allocated contingency) and programme implications (8 week delay to anticipated completion). It has been recommended that a lessons learnt exercise is undertaken of these issues to inform the delivery of future projects at the UHB.

The enabling works contract was completed within the 4-month contract period; and within the required cost and quality parameters. However, associated contracted documentation was not signed in a timely manner.

Review of change management, target cost production and valuation assessments noted that appropriate arrangements had been applied. However some issues were identified including:

- Discrepancies in cash-flow reporting;
- Irregular dashboard submissions to the Welsh Government; and
- Requirement for a project specific Project Board noting the current reporting process [Grange University Hospital Project Board] is scheduled to dissolve in April 2021.

Noting the progression of the construction of the HSDU during the Covid pandemic, it was confirmed that the SCP and UHB had implemented appropriate procedures to ensure a safe working environment.

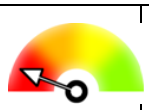
Accordingly, against this context, and at the current stage of the project, the level of assurance given is **reasonable.**

RATING	INDICATOR	DEFINITION
Reasonable Assurance		Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the ability of addressing the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Follow up			✓	
2	Design Development			✓	
3	Target Cost / Valuation			✓	
4	Enabling Works			✓	
5	Change Management				✓
6	Working safely during Coronavirus				✓

Design of Systems/Controls

The findings from the review have highlighted **no** issues that are classified as a weakness in the system control/ design at the project.

Operation of Systems/Controls

The findings from the review have highlighted **6** issues that are classified as a weakness in the operation of the designed system/control at the project.

6. Summary of Audit Findings

Follow Up

That previously agreed management actions had been implemented.

The status of actions arising from the previous review (report issued April 2019: *Reasonable Assurance*) was as follows:

Closed	Partially implemented	Outstanding	Total
4	1	1	**6**

The detail in support of the above summary is included in **Appendix B**.

Accordingly, **reasonable assurance** has been determined in respect of the action taken to address previously agreed audit recommendations.

Design Development

That the design was sufficiently progressed with users and signed off in accordance with the development programme and at target cost; and that equipment requirements were fully considered with the design development and prior to the commencement of works on site.

The design for the HSDU project, presented to support the target cost and submitted FBC, was reflective of the service requirements, and endorsed by users, to meet the wider changes to theatre provision at the UHB [highlighted by the opening of the Grange University Hospital]; and reflective of the equipment requirements to be able to provide the service.

However, issues arising from the procurement exercise of project critical equipment (washers and disinfectors) had a significant implication on the design development and project cost.

The timeline for procurement covered a period of 8 months [initiation to contract award] - a timeline which management advised was longer than anticipated. Additionally, the preferred supplier whose product specifications were reflected within the building's design development, did not participate in the tender exercise. As well as the selected supplier being at a higher cost, the changes in equipment specifications led to significant changes to the building design to satisfy effective operation of the equipment. A review of the robustness of the internal procedures to manage participation of contractors / suppliers in tender exercises is recommended (**recommendation 1**).

Financially, the changes to design and specifications account for use of 76% of the contingency applied at the project; and an 8-week delay incurred to the programme [planned completion extended from April 2021 to June 2021].

These issues should be assessed as part of a lessons learnt exercise to inform the delivery of future projects within the UHB (**recommendation 2**).

Given the design changes applied to the HSDU project, the implications have been managed well with regular monitoring and reporting [monthly Progress and Commercial meetings]; including the impact of any further changes that may be required. It has also been clearly communicated to all parties the design is considered frozen and that there is no further scope for further design changes.

Whilst recognising the impact of the actual equipment vs. planned equipment on design development and programme delivery **reasonable assurance** has been determined.

Target Cost / Valuation

That the target cost had been appropriately determined and approved; and that appropriate interim valuation arrangements were applied at the project.

The total target cost applied to the HSDU project is £10,715,838. The UHB's cost adviser assessed the market testing of the packages to ensure value for money in reaching the sum.

A review of eight market tested packages (combined value: £5,016,794 / 47% of the total target cost) was undertaken as a part of the current audit and the following noted:

- 4 packages where the lowest tender was selected;
- 3 packages where the lowest tender was not selected, however an appropriate explanation was evidenced; and
- 1 package called off an approved framework.

For all packages, review of the supporting documentation confirmed that value for money had been adequately determined.

Cost adviser valuation assessment arrangements were noted, affirming the value of the work completed prior to passing for approval for payment by the UHB. A sample of payments [SCP and appointed advisers] were reviewed to confirm completeness and timeliness:

	Number of valuations sampled	Total sampled £
Project Manager	3	12,759
Cost Adviser	3	14,020
Supervisor	3	11,595
SCP	3	2,357,074

All had been paid in a timely manner (and in accordance with the contractual requirements). For two payments reviewed [SCP: September 2020 and November 2020] there were discrepancies between the valuation figure and that reported on the cash-flow (**recommendation 3**). In both instances, the cash-flow reported a lower figure.

We sought to undertake a reconciliation of the cash-flow / budget position and the monthly dashboard returns to Welsh Government [which report into the All Wales Capital Programme meetings]. However, this was not possible as only one submission had been made from March 2020 to the date of reporting (**recommendation 4**). It was also noted that the completed dashboard had not been presented to Project Board for scrutiny/challenge (**recommendation 5**).

Appropriate arrangements had been applied in respect of the market testing and target cost production exercise. However, noting the discrepancies in cash-flow reporting and lack of submission of Welsh Government dashboard reports, **reasonable assurance** has been determined.

Enabling Works

That appropriate contractual arrangements were in place; and that the enabling works were delivered within time, cost and quality parameters.

The enabling works commenced 7 October 2019 and were completed on 24 January 2020, in accordance with the agreed programme of works; accepting there was a 2-week delay associated with drainage on the Grange University Hospital construction site. Works were completed within budget i.e.:

£	
249,262	Budget for enabling works
33,671	Transfer from main works (demolition material used as fill)
282,933	**Total budget for enabling works**
271,396	Total expenditure on enabling works
11,537	**Total underspend**

A delay in the completion of the contract documentation for the enabling works was noted (**recommendation 6**).

Recognising the enabling works were completed within the cost and quality parameters; but that contract documentation had not been signed in a timely manner, **reasonable assurance** has been determined.

Change Management

That changes were processed / authorised in accordance with the contract and local internal control procedures.

Section 8 of the Project Execution Plan (PEP) details the change management process noting that: *The Project Manager cannot vary the contract which exists between the Employer and the Contractor nor may they make any material alteration, addition or omission from the approved design without the Employer's knowledge and consent.*

To the end of November 2020 a total of 13 approved compensation events with a total value of £354k had been issued.

All of the changes reviewed were progressed in accordance with the formal contractual arrangements and defined delegated limits.

Noting the above, **substantial assurance** has been determined in respect of the change management procedures applied at the project to date.

Working safely during Coronavirus

That the financial and delivery implications of procurement and contractual issues (both pre & post Covid) were appropriately managed; and that safe working practices were established and monitored.

Management advised that there had been no variations to the contract as a result of Covid.

Covid site-specific operating procedures were issued by the SCP; to be applied to all construction staff on site, including sub-contractors. Monitoring of compliance to the site rules was undertaken on a routine basis with formal reporting through the monthly contractor's progress reports. No breaches were reported at the project to date.

The UHB also published Covid related procedures applicable across all their premises.

The cost report to end November 2020 includes £9k for Covid-specific costs attributed to the cleaning requirements and site access.

Recognising the procedures in place to ensure a safe working environment, **substantial assurance** has been determined.

7. Summary of Recommendations

The audit findings, recommendations are detailed in **Appendix A** together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Current year recommendations	-	5	1	**6**
Prior year recommendations	-	2	-	**2**
Actioned since fieldwork	-	-	*1*	***1***
Total recommendations	**-**	**7**	**-**	**7**

Finding 1: Lessons learnt	Risk
Issues arising from the procurement exercise of project critical equipment (washers and disinfectors) had a significant implication on the design development and project cost of the HSDU project The timeline for procurement covered a period of 8 months – initiation (July 2019) to contract award (April 2020). A timeline which management advised was longer than anticipated. Further to this the preferred supplier whose product specifications were reflected in the building design, did not participate in the tender exercise as anticipated. As well as the selected supplier being at a higher cost, the changes in equipment specifications led to significant changes to the building design to satisfy effective operation of the equipment. There was no evidence of review of the arrangements applied in ensuring prospective tenderers participate in the procurement exercise; nor how the UHB determined their preferred supplier at pre-contract stages to inform the project design. Financially, the changes to design and specifications account for use of 76% of the contingency applied at the project; and an 8-week delay applied to the programme [planned completion extended from April 2021 to June 2021]. The approach of placing reliance on one supplier [and the associated project critical equipment specifications] to develop and cost a building design; and the subsequent impact on the procurement exercise should be reviewed to ensure lessons learnt can be applied for the benefit of future projects.	The design is not appropriate to operational needs.

Recommendations 1 & 2	Priority level
1. The UHB should have appropriate procedures in place to ensure that when determining the preferred supplier to inform the design, confirmation is received of willingness to participate in the subsequent procurement/market testing exercise (**O**).	**Medium**
2. Lessons learnt from the development of the design and equipment procurement exercise should be captured, either separately or as part of the formal post project evaluation (**O**).	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. It is not completely clear what exactly went wrong with the procurement process and why it took so long to select a preferred supplier. The lessons learnt exercise will attempt to address both issues.	Strategic Capital & Estates Programme Director *In liaison with NWSSP: Procurement Services* May 2021

Finding 2: Cost Adviser reporting	Risk
A sample of 12 valuation payments, for the SCP and appointed advisors, was reviewed to confirm completeness and timeliness of payment. All payments were made in a timely manner. However, for two of the SCP payments reviewed, there were discrepancies between the valuation figure and that reported on the cash-flow, a prepared by the Cost Adviser: **Date of valuation** / **Amount per cash-flow** / **Amount per valuation** / **Difference** Valuation 9 – 30/09/2020 / £510,767 / £518,060 / £7,293 Valuation 11 – 25/11/2020 / £864,326 / £866,026 / £1,700 At the date of fieldwork, the cash-flow reporting for SCP expenditure was £8.9k lower than expended. Whilst it is recognised that the UHB's general ledger code is recording the correct payments, there is the expectation that Cost Adviser's reports accurately reflect the valuations that have been assessed and passed for payment.	Cost reporting does not reflect actual expenditure.
Recommendation 3	**Priority level**
For accuracy of reporting, the Cost Adviser cash-flows should be reconciled to UHB payments made. (**O**)	**Low**

Management Response	Responsible Officer/ Deadline
Agreed; and has already been addressed.	Head of Capital Finance *In liaison with the Cost Adviser* Actioned since fieldwork

Finding 3: Welsh Government dashboard reporting	Risk
All Wales Capital Programme (AWCP) funded projects should prepare monthly dashboard returns. These are reviewed as part of the AWCP monthly meetings providing a summary of project progress to date and key risks. Review of the AWCP submissions, from March 2020 to date of reporting, noted that there has only been one report received for the HSDU project [November 2020]. There is also an expectation that Welsh Government returns are presented to Project Board for scrutiny/challenge prior to submission. There is no separate Project Board for the HSDU project, rather it is a standing agenda item on the Grange University Hospital (GUH) Project Board. Noting that the GUH project is now complete, with a final Project Board anticipated in April 2021, appropriate arrangements need to be in place to ensure a level of scrutiny and monitoring is maintained of the HSDU project until completion / handover as a minimum.	Poor financial control and risk management over the project.
Recommendations 4 & 5	**Priority level**
4. The monthly Welsh Government dashboard reports should be submitted in accordance with expectation (**O**).	**Medium**
5. An HDSU Project Board should be established to take through to completion / handover (as a minimum) (**O**)	**Medium**

Management Response	Responsible Officer/ Deadline
4. Agreed. The Welsh Government reports will continue to be submitted.	Strategic Capital & Estates Programme Director March 2021
5. Agreed. The GUH Project Board currently fulfils this function and alternative arrangements will be made after the April 2021 meeting.	Strategic Capital & Estates Programme Director April 2021

Finding 4: Contract Documentation (Enabling Works)	Risk
The commencement date of the enabling works was 7 October 2019. Recognising the impact on the ability to visit UHB sites, due to Covid restrictions, reference was only able to be made to a copy of the NHS seal of registers and not the actual signed contract. The documentation reviewed indicated that the earliest date of signing of the contract was 31 October 2019. Review of minutes of the SCP monthly progress meetings noted that the enabling works contract had been submitted to the UHB for acceptance on 17 October 2019. The contract, therefore, was accepted by both parties after the commencement; increasing the risks of project progression without adequate contractual arrangements in place.	The project progresses at risk without appropriate approvals.
Recommendation 6	**Priority level**
At future projects: Contract documentation should be signed in a timely manner, prior to the commencement of works.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. The importance of a quick turnaround of contract documents has been relayed to the various project SCPs, PMs and ABUHB corporate services.	Strategic Capital & Estates Programme Director At future projects

Prior ref	Recommendation	Responsibility & timeline	Action / Status	Updated responsibility & timeline	Current year priority rating
Medium					
1	Acceptance certificates should be issued at projects to reflect the assignment of responsibilities.	Strategic Capital & Estates Programme Director April 2019	**Outstanding** There was no evidence of acceptance certificates provided. Whilst it is acknowledged that the project will be entering its latter stages as the new financial year commences, there remains the need to have identifiable ownership to oversee the project completion, and post completion (i.e. snagging / defect management).	Strategic Capital & Estates Programme Director April 2021	**Medium**
2	(a) To enhance current arrangements, Project Team terms of reference should be updated. (b) A mapping exercise [resources and skills] should be undertaken with remedial action taken to identify any gaps.	Strategic Capital & Estates Programme Director April 2019	**Closed** The terms of reference were appropriately updated with appropriate membership from the relevant lines of service linked to the project. It is noted, however, that a further review of the terms of reference will be required noting that two members listed have since left the UHB.	N/A	N/A

Prior ref	Recommendation	Responsibility & timeline	Action / Status	Updated responsibility & timeline	Current year priority rating
3	At future stages of the project, contract documentation should be signed prior to the commencement of respective commissions / works.	Strategic Capital & Estates Programme Director April 2019	**Closed** Noting the current pandemic situation, the ability to visit site to review contractual documentation was reduced. Assurance has therefore been placed on the NHS Seal Register. Whilst it couldn't be directly confirmed that the contract documentation was signed prior to the commencement of the works, it could be confirmed they had been signed by the UHB.	N/A	N/A
4	a) The risk register should be reviewed and updated for the current phase of the project, and frequency of subsequent reviews suitably defined. b) The detail of the risks, and their associated countermeasures, should be reviewed to ensure they are SMART.	Strategic Capital & Estates Programme Director April 2019	**Partially implemented** The risk register has been appropriately updated for the current phase of the project. All risks included in the register should have identified countermeasures. However, six of the recorded risks [marked as current / future] do not have recorded mitigating actions.	Strategic Capital & Estates Programme Director April 2021	**Medium**
5	A formal KPI process should be introduced at the current stage of the	Strategic Capital & Estates Programme Director	**Closed.**	N/A	N/A

Prior ref	Recommendation	Responsibility & timeline	Action / Status	Updated responsibility & timeline	Current year priority rating
	project to monitor the performance of the SCP and advisers.	May 2019	A formal KPI process is being followed in relation to this project.		
6	Key stakeholders and users should formally sign-off / approve the details to be included in the FBC; in addition to any changes that may be required to completion of the project.	Strategic Capital & Estates Programme Director On-going	**Closed** Appropriate sign-offs are in place and retained.	N/A	N/A

Appendix C – Audit Assurance Ratings

Substantial assurance - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

Reasonable assurance - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

Limited assurance - The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

No Assurance - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

** Unless a more appropriate timescale is identified/agreed at the assignment.*

Client Organisation	Aneurin Bevan University Health Board
Audit title	Hospital Sterilisation & Disinfection Unit (HSDU) Project
Audit reference	SSU_ABU_2021_01
Final Report Date	17 March 2021
Auditor / Supervisor	Felicity Quance

I would be very grateful if you would please take a moment to complete the below questionnaire which will enable us to ensure that we provide a high quality service. Feedback will also be also reflected within our key performance information reported to the Audit Committee.

	QUERY (enter "X" alongside)	Yes	No	Partially	n/a	Any further comments
1	**Engagement & Communication** Were you satisfied with the way the audit team engaged with you and colleagues?					
2	**Professionalism** Was the audit conducted in a positive, professional manner and respectful of your work commitments?					
3	**Report** Was the work reported in a clear, constructive way?					
4	**Impact** Was the audit beneficial eg providing assurance regarding current arrangements, or supporting improvements?					

What words would you use to describe the audit service you have received? Please feel free to enter up to six words into the boxes below:		

If you have any additional comments or suggestions, please add them below:

Form Completed by	
Date	

Thank you very much for taking time to complete this questionnaire. Please return by email: **huw.richards@wales.nhs.uk** or post :**Huw Richards, Deputy Director (SSU), NWSSP Audit & Assurance, Floor 3, Companies House, Crown Way, Cardiff, CF14 3UB**
Alternatively, please feel free to call me on: **029 2090 5312**